INDEX MEDICUS



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The JOURNAL of the Kentucky State Medical Association

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OF MEDICINE

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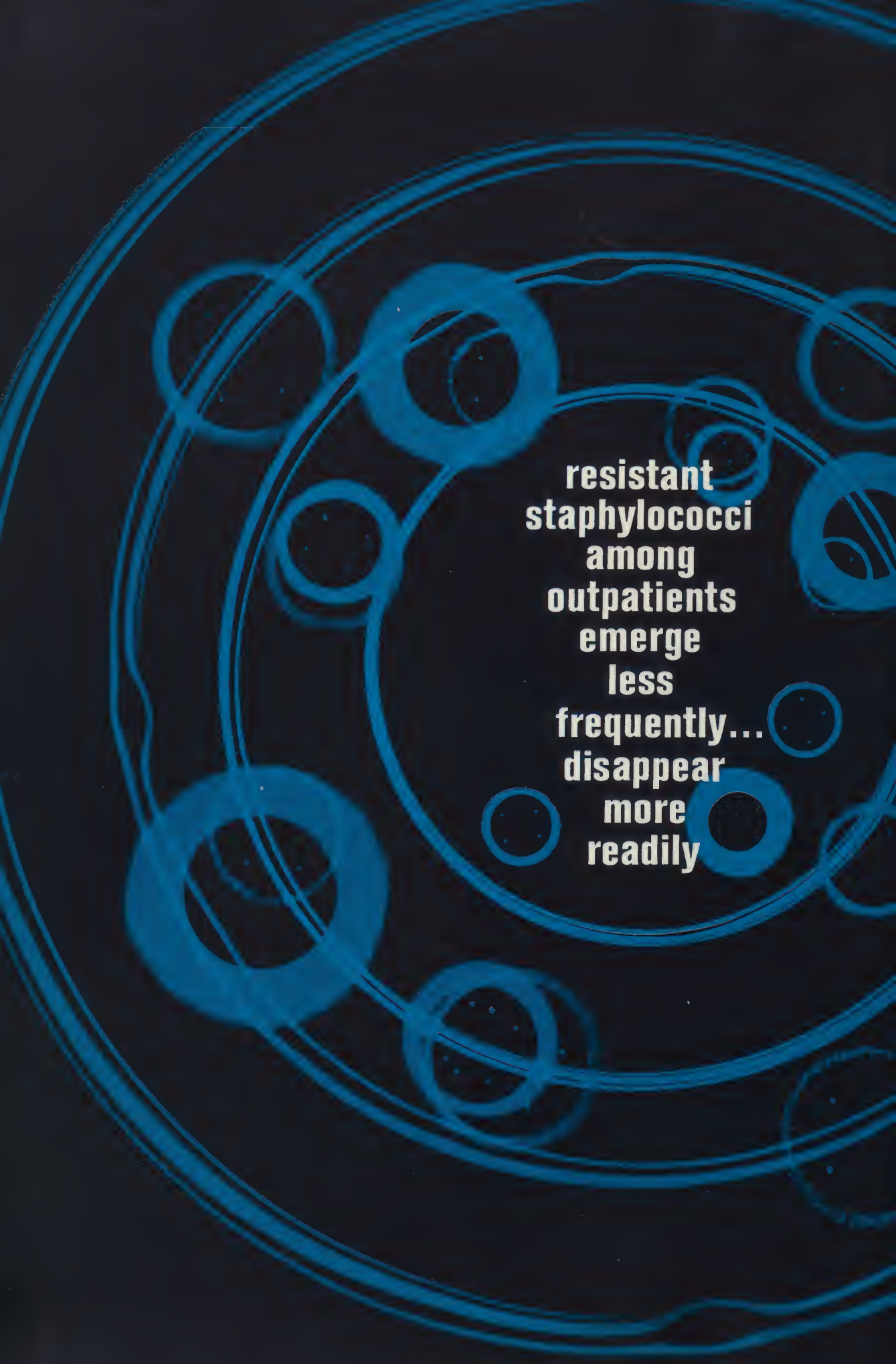
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ORGANIZED 1851

JANUARY 1961 · VOLUME 59 · NUMBER 1

INDEX MEDICUS


resistant
staphylococci
among
outpatients
emerge
less
frequently...
disappear
more
readily

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chloramphenicol, Parke-Davis

"Resistance to chloramphenicol was surprisingly infrequent (0-5%)" among strains of staphylococci isolated from outpatients over a 5-year period. It was impressive to note that less than 6% of 310 strains isolated from patients treated in the emergency room were resistant to CHLOROMYCETIN. Moreover, it would appear "...that chloramphenicol-resistant staphylococci disappear more readily after leaving the hospital environment."[1]

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References: (1) Bauer, A. W.; Perry, D. M., & Kirby, W. M. M.: *J.A.M.A.* 173:475, 1960. (2) Goslings, W. R. O., & Büchli, K.: *Arch. Int. Med.* 102:691, 1958. (3) Goodier, T. E. W., & Parry, W. R.: *Lancet* 1:356, 1959. (4) Fisher, M. W.: *Arch. Int. Med.* 105:413, 1960. (5) Petersdorf, R. G., *et al.*: *Arch. Int. Med.* 105:398, 1960. (6) Glas, W. W., in Symposium on Antibacterial Therapy, Michigan & Wayne County Acad. Gen. Pract., Detroit, September 12, 1959, p. 7. (7) Modarress, Y.; Ryan, R. J., & Francis, Sr. C. E: *J. M. Soc. New Jersey* 57:168, 1960. (8) Rebhan, A. W., & Edwards, H. E.: *Canad. M. A. J.* 82:513, 1960.

IN VITRO SENSITIVITY OF COAGULASE-POSITIVE STAPHYLOCOCCI TO CHLOROMYCETIN FROM 1955 TO 1959*



These sensitivity tests were done by the disc method on 310 strains of coagulase-positive staphylococci. Strains were isolated from patients seen in the emergency room. It should be noted that among inpatients, resistant strains were considerably more prevalent.

*Adapted from Bauer, Perry, & Kirby[1]

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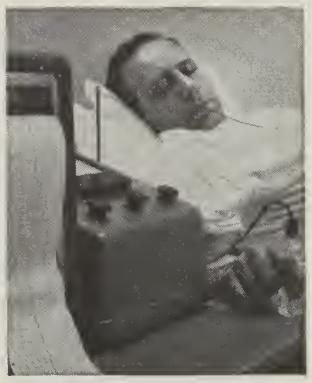
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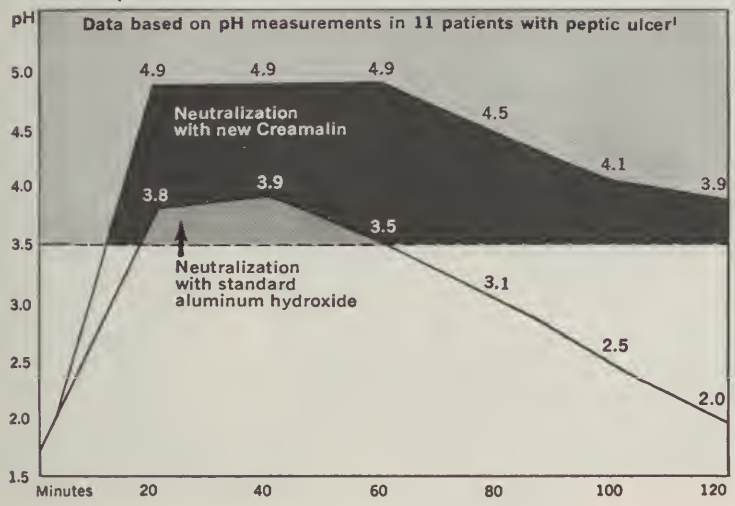
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At the site of peptic ulcer



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1. Data in the files of the Department of Medical Research, Winthrop Laboratories. 2. Hinkel, E. T., Jr.; Fisher, M. P., and Tainter, M. L.: **J. Am. Pharm. A.** (Scient. Ed.) 48:384, July, 1959.

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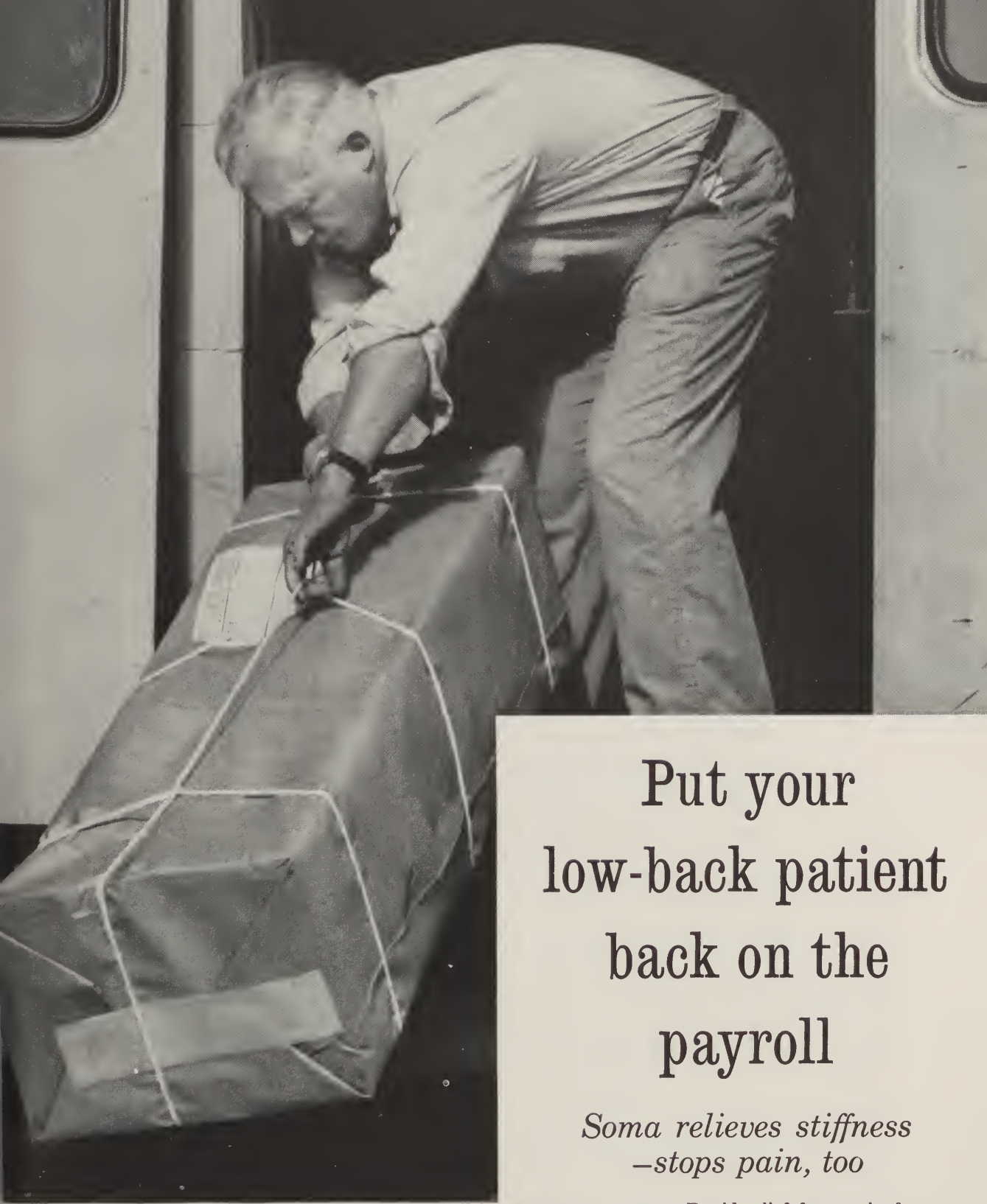
1. Weissberg, G.: Clin. Med., June 1960.

2. Spoor, H. J.: N. Y. St. J. Med., Oct. 15, 1958.

*patent pending
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MESSAGE FROM THE PRESIDENT

PREVENTATIVE medicine is becoming a greater part of the practice of each physician as medicine progresses. Close behind heart disease and cancer, as a cause of death, are automobile accidents. In 1959, 37,800 persons were killed and 1,400,000 were injured. If a new contagious disease were to cause this same mortality and morbidity in one year, the nation would be in panic. This day-by-day massacre is now so routine to each of us that we read the figures in the daily papers and hear the reports over the radio and television with absolute callousness and do nothing as doctors or citizens about it.

At its June meeting in 1959, the AMA recognized that organized medicine should take any steps that it could to prevent automobile accidents. A committee was appointed to seek the means through which this could be done. Following AMA action, the KSMA House of Delegates at the September 1960 meeting authorized the formation of a "Traffic Safety Committee" for the study of the problem in our state.

Before the committees make any recommendations there are two things which the individual physician can do as his part in this program. The first is to drive carefully, obeying the traffic regulations and, as far as he is able, seeing that he does not contribute a personal accident to the daily toll. The second is to have safety belts installed in his car and to use them. The AMA has recommended their use and the research at Cornell University has clearly shown that there is a marked reduction in deaths as well as diminution in the severity of injuries in many accidents when the victims were using safety belts. They have proven this statistically and have also reached the same conclusions from work with dummies under controlled conditions.

If each member of KSMA would become an apostle for safety he would not only encourage his patients by his practice and preaching to practice "preventative medicine" on the highways but he would enjoy a safer and happier New Year.

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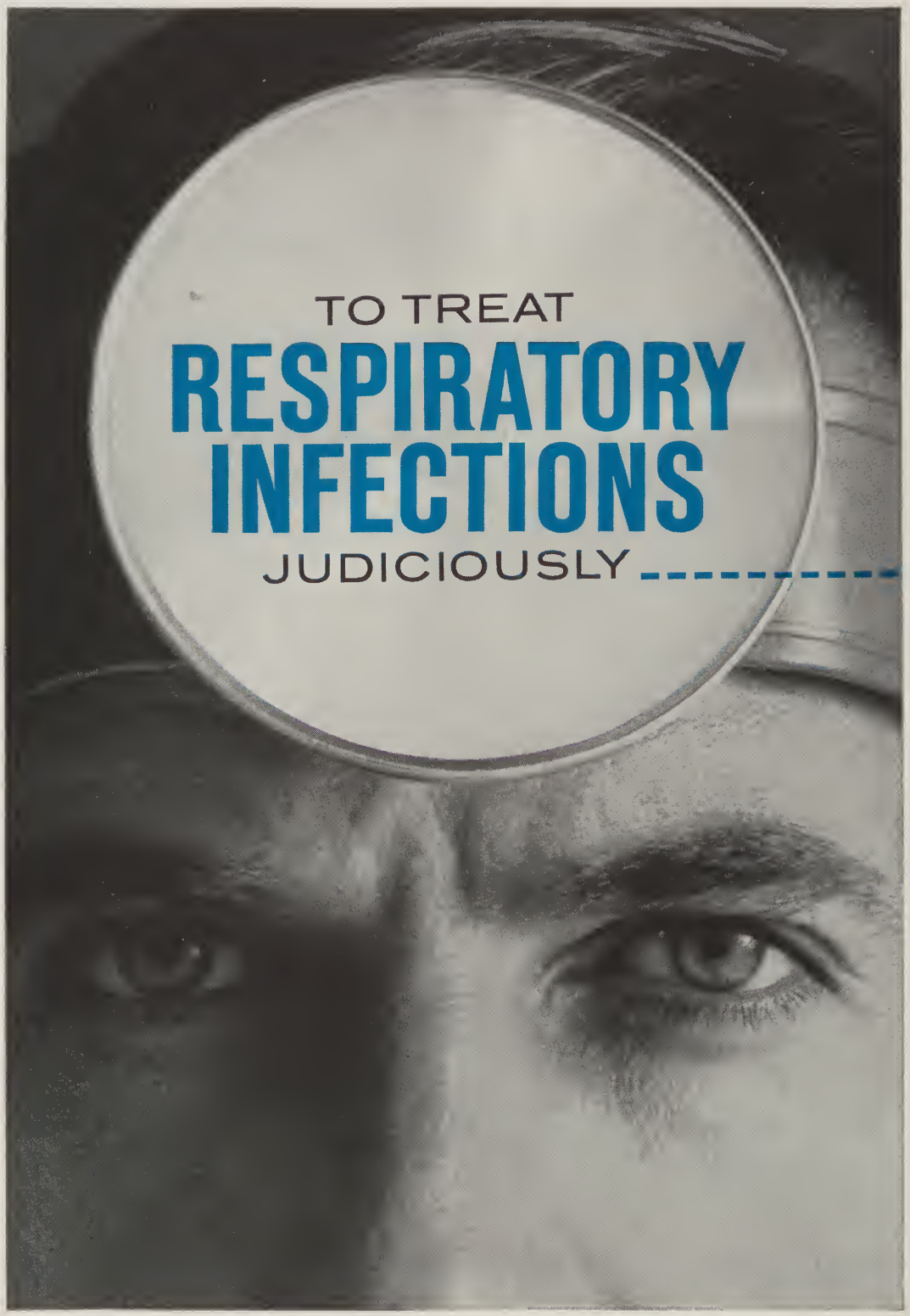


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Literature on request

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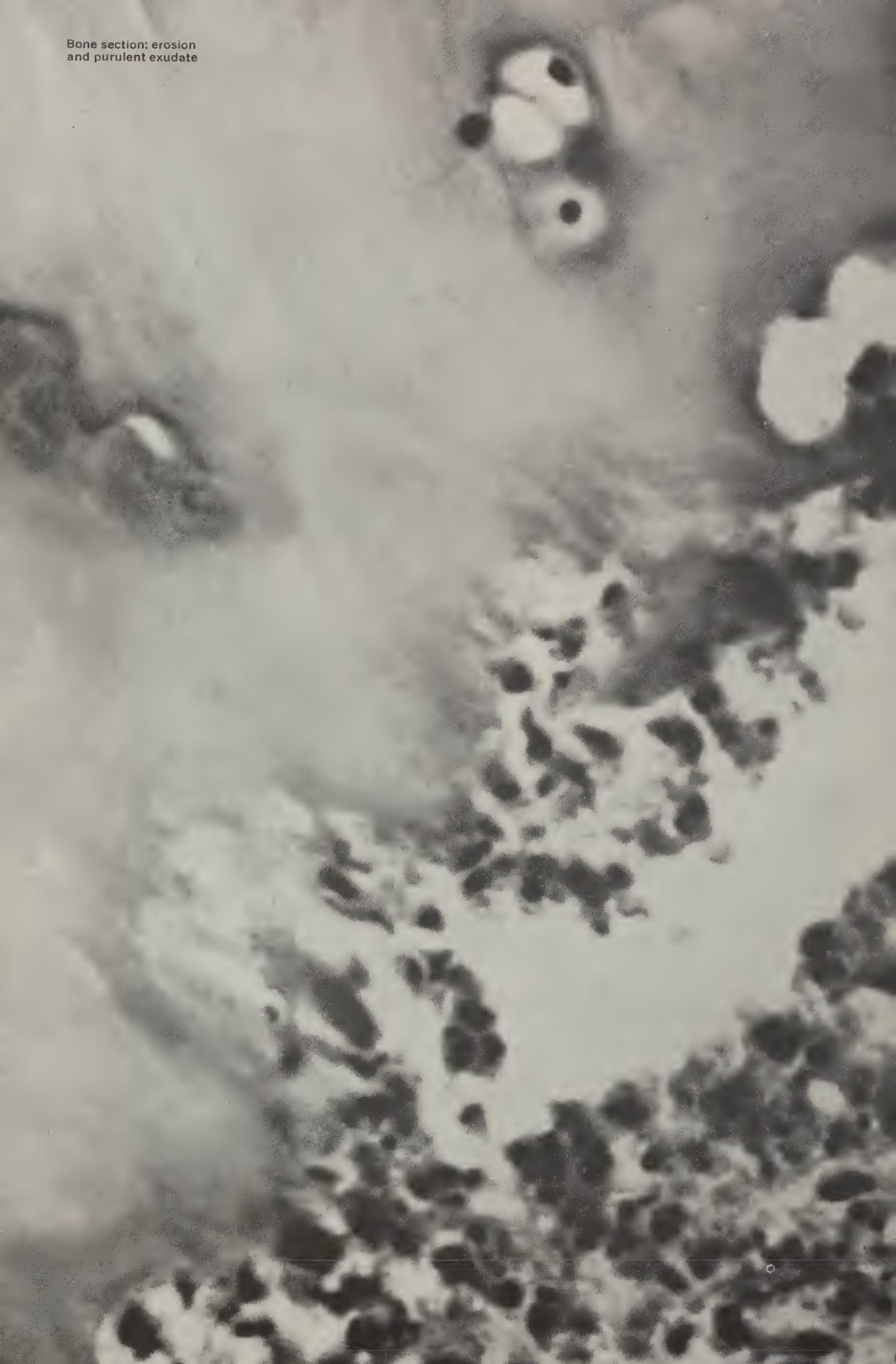
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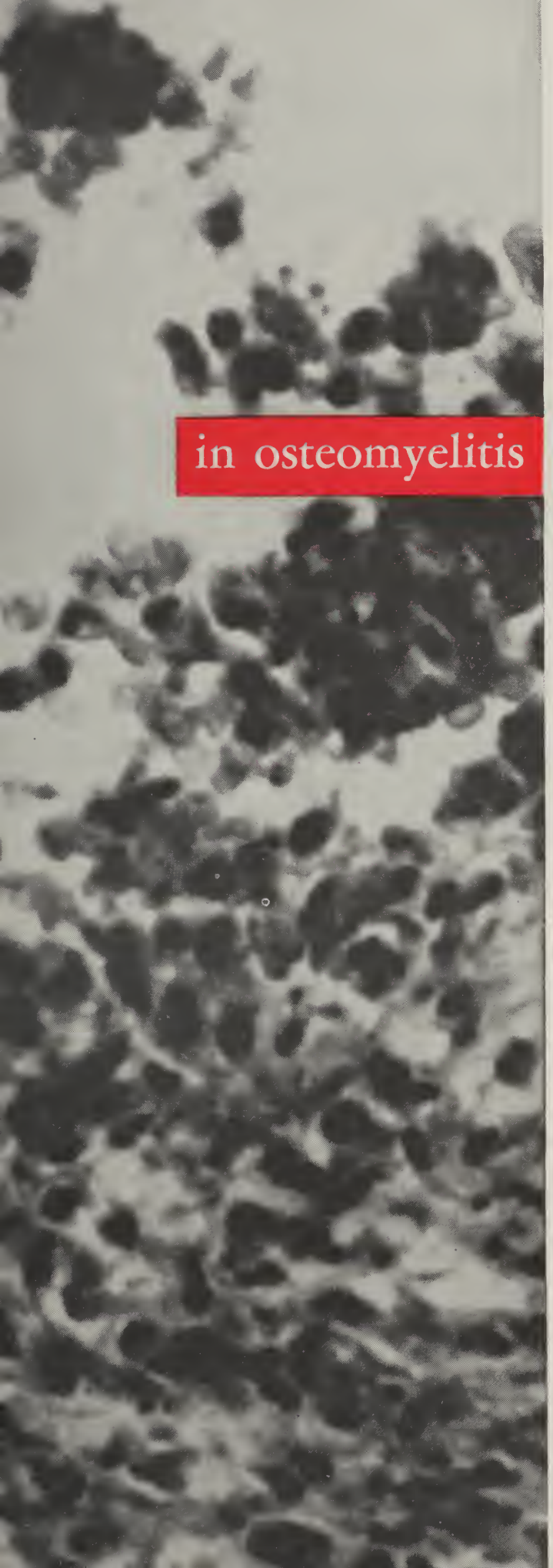
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THE INSURANCE PAGE



Those Pesky Insurance Forms!

ONE of the least enjoyable of the tasks which we physicians must constantly perform is that of completing the many Blue Shield or health insurance forms which our patients bring to us.

Even if one is fortunate enough to have a secretary or office assistant who can fill out these forms for him, it is still necessary that he check each one for accuracy, supply information not given in the office records, and sign the form. All of this takes time and effort.

The constantly increasing number of these forms which must be completed attests to the fact that the American public has found prepayment for health care the most practical way of solving the economics of such care, and of paying for a large part of the services which we provide. Almost two out of every three individuals in our country today (an estimated 117 million) have insurance to help pay for surgical care, and a somewhat smaller number have some insurance protection against the cost of physicians' services other than surgery. These numbers are increasing greatly from year to year.

Can Be Thankful

Voluntary prepayment for health care, we believe, is here to stay. We can be thankful that this is so, for it is largely due to this fact that we have escaped a system of socialized medicine such as that which Great Britain has had for many years. It is also a self-evident fact that through our prepayment mechanisms may people today can afford to pay for private medical care, who without this help would have become dependent on charity for their health care.

Completely essential to the operation of any prepayment plan, be it Blue Shield or private insurance, is the certification, given by the responsible physician, as to the fact of illness and the nature and extent of the treatment rendered.

Failure by the physician to furnish such information will prevent the patient from receiving the financial assistance for which he has budgeted. Unnecessary delay in completing the forms may place a temporary hardship on the patient, especially if his insurance is designed to protect him against loss of income, as well as against the cost of medical care. In other words, completion of these forms is as truly a part of the service which we give to our patients (even though secondary in importance) as are the medical treatments which we render.

Some physicians have objected to the completion of the claim forms, on the ground that revealing the nature of the patient's illness might constitute a violation of confidence and might be an encroachment on the traditional doctor-patient relationship.

Attitude Not Justified

This attitude is most certainly not justified, since the contract between the prepayment plan and the patient has provided that the physician may give to the insuring organization such information as is necessary to make possible a prompt and fair settlement of the claims.

Every effort has been made, and will continue to be made, to simplify and standardize the claim forms as much as possible, in order to reduce the physician's work and conserve his time in completion of the forms.

One final thought: how many forms would you have to complete, and how many questions would you have to answer for each case you treated, if compulsory governmental insurance ever became the law of the land? Have you ever served in the Army or Navy Medical Corps, Doctor?

Let's try to think about *that* when we become irritated by our voluntary health insurance forms.

W. V. Pierce, M.D.



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PHARMACEUTICALS RESEARCH

WASHINGTON NEWS DIGEST

Washington, D. C.—Physicians are being urged to cooperate fully to get their states to participate as soon as possible in the new federal-state program for medical care of needy and the near-needy older persons.

The medical profession also has been alerted to the dangers of relaxing its opposition to tying in medical care of the aged with Social Security. It is probable that the Kennedy Administration will try in 1961 to get Congressional approval of such legislation.

E. Vincent Askey, M.D., president of the American Medical Association, pointed out to the recent Washington meeting of the AMA House of Delegates that proponents of the Social Security approach had a pledge of support from the successful Democratic candidate for President.

"While our profession clearly may face a hard struggle in the 87th Congress on the issue of medical aid for the aged under Social Security, there is no ground for defeatism!" Doctor Askey said.

"Our cause is far from lost. We know that our policy position is in the best interests of all Americans, the aged included, and our willingness to defend this policy must be strengthened and maintained."

Doctor Askey reminded the House of Delegates that "medicine has many friends in both parties in Congress today."

A few days later, Sen. Harry F. Byrd (D., Va.), chairman of the Senate Finance Committee which handles Social Security legislation, reiterated his opposition to a compulsory medical care plan under Social Security. He said:

"I am opposed to the (Democratic party) platform recommendation for compulsory medical service and hospitalization under the Social Security system. I am convinced this would lead to socialized medicine with the possibility that it would bankrupt the Social Security trust fund. This matter came before the Finance Committee and was fought out in the post-convention session of Congress last August. The Senate voted 51 to 44 in opposition to the Democratic platform proposal, and instead adopted a fair plan for medical service and hospitalization for those in need of it."

Doctor Askey urged that all county and state medical associations provide "the medical leadership necessary to implement the Mills-Kerr bill (the new federal-state program) as rapidly as possible." And the House of Delegates adopted such a resolution.

"We must put forth a sincere and concentrated effort during the coming year to make the Mills-Kerr law effective, to show that it can, practically as well as potentially, solve the problem of medical care for the aged," Doctor Askey said.

Present-elect John F. Kennedy's first Cabinet appointment was Gov. Abraham Ribicoff of Connecticut as Secretary of Health, Education and Welfare—the official with primary responsibility for carrying out the federal part of the Mills-Kerr program.

Ribicoff, 50, was an early supporter of Kennedy for the Presidential nomination. He was twice elected governor of Connecticut. Before that, he served as a Hartford, Conn., police judge, a member of the state legislature and a member of the national House of Representatives. As governor, he inaugurated a comprehensive traffic safety program with strong penalties.

•

THE SABIN ORAL POLIO vaccine will not be available in sufficient quantity in 1961 for large scale use.

Leroy E. Burney, M.D., Surgeon General of the U.S. Public Health Service, told the recent Clinical Meeting of the AMA that many problems involved in taking the oral vaccine out of the laboratory and into mass production had not been solved.

In light of this fact, both the AMA House of Delegates and Doctor Burney urged that the widest possible use of the Salk vaccine be encouraged. Doctor Burney said that large numbers of the U.S. population, including almost half of the children under 5, had not been fully vaccinated with the effective Salk vaccine.

Doctor Burney said the problems of integrating the oral vaccine into the present program of immunization against polio "are many and complex."

"Only the future can tell whether control of poliomyelitis will be accomplished through a live, orally administered vaccine, the killed vaccine, or a combination of both," Doctor Burney said.

•

THE FOOD AND DRUG Administration issued stricter rules, some effective January 8 and others effective March 9, governing promotion and marketing of prescription drugs. The new regulations are designed to insure safe use of the drugs.

Under the new regulations, manufacturers must disclose hazards, as well as advantages, of the drugs in promotional material sent to physicians. Manufacturers can be denied permission to market drugs they refuse to permit FDA inspection of manufacturing methods, facilities, controls or records.

The FDA deferred until later action on its pro-

(Continued on Page 74)



if you're treating a coccal infection...

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"STAPH-CIDAL" PENICILLIN

Staphcillin™

sodium dimethoxyphenyl penicillin
FOR INJECTION

UNIQUE—BECAUSE IT
RETAINS ANTIBACTERIAL
ACTIVITY IN THE PRESENCE OF
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NEW SYNTHETIC PENICILLIN FOR "RESISTANT" STAPH

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OFFICIAL PACKAGE CIRCULAR
November, 1960

STAPHCILLIN™

(sodium dimethoxyphenyl penicillin)
For Injection

DESCRIPTION

STAPHCILLIN is a unique new synthetic parenteral penicillin produced by Bristol Laboratories for the specific treatment of staphylococcal infections due to resistant organisms. Its uniqueness resides in its property of resisting inactivation by staphylococcal penicillinase. It is active against strains of staphylococci which are resistant to other penicillins.

Each dry filled vial contains: 1 Gm. STAPHCILLIN (sodium dimethoxyphenyl penicillin), equivalent to 900 mg. dimethoxyphenyl penicillin activity.

INDICATIONS

STAPHCILLIN is recommended as specific therapy only in infections due to strains of staphylococci resistant to other penicillins, e.g.:

Skin and soft tissue infections: cellulitis, wound infections, carbuncles, pyoderma, furunculosis, lymphangitis and lymphadenitis.

Respiratory infections: staphylococcal lobar or bronchopneumonia, and lung abscesses combined with indicated surgical treatment.

Other infections: staphylococcal septicemia, bacteremia, acute or subacute endocarditis, acute osteomyelitis and enterocolitis.

Infections due to penicillin-sensitive staphylococci, streptococci, pneumococci and gonococci should be treated with Syncillin® or parenteral penicillin G rather than STAPHCILLIN. Treponemal infections should be treated with parenteral penicillin G.

DOSAGE AND ADMINISTRATION

STAPHCILLIN is well tolerated when given by deep intragluteal or intravenous injection.

As is the case with other antibiotics, the duration of therapy should be determined by the clinical and bacteriological response of the patient. Therapy should be continued for at least 48 hours after the patient has become afebrile, asymptomatic and cultures are negative. The usual duration has been 5-7 days.

Intramuscular route: The usual adult dose is 1 Gm. every 4 or 6 hours. Infants' and children's dosage is 25 mg. per Kg. (approximately 12 mg. per pound) every 6 hours.

Intravenous route: 1 Gm. every 6 hours using 50 ml. of sterile saline solution at the rate of 10 ml. per minute.

**Warning:* Solutions of STAPHCILLIN and kanamycin should not be mixed, as they rapidly inactivate each other. Data on the results of mixing STAPHCILLIN with other antibiotics are being accumulated.

DIRECTIONS FOR RECONSTITUTION

Add 1.5 ml. sterile distilled water or normal saline to a 1 Gm. vial and shake vigorously. Withdraw the clear, reconstituted solution (2.0 ml.) into a syringe and inject. The reconstituted solution contains 500 mg. of STAPHCILLIN per ml. Reconstituted solutions are stable for 24 hours under refrigeration.

For intravenous use, dilute the reconstituted dose in 50 ml. of sterile saline and inject at the rate of 10 ml. per minute.

*This statement supersedes that in the Official Package Circulars dated September and/or October, 1960.

(continued)

MICROBIOLOGICAL AND PHARMACOLOGICAL PROPERTIES

In vitro studies show that STAPHCILLIN is a bactericidal penicillin with activity against staphylococci resistant to penicillin G. Strains of staphylococci so far tested have been sensitive to STAPHCILLIN *in vitro* at concentrations of 1-6 mcg. per ml. These levels are readily attained in the blood and tissues by administration of STAPHCILLIN at the recommended dosage. This unique attribute is probably due to the fact that STAPHCILLIN is stable in the presence of staphylococcal penicillinase. STAPHCILLIN also resists degradation by *B. cereus* penicillinase. The antimicrobial spectrum of STAPHCILLIN with regard to other microorganisms is qualitatively similar to that of penicillin G; but considerably higher concentrations of STAPHCILLIN are required for bactericidal activity than is the case with penicillin G.

STAPHCILLIN is rapidly absorbed after intramuscular injection. Peak blood levels (6-10 mcg./ml. on the average after a 1.0 Gm. dose) are attained within 1 hour; and then progressively decline to less than 1 mcg. over a 4 to 6 hour period. It is poorly absorbed from the gastrointestinal tract. STAPHCILLIN is rapidly excreted by the kidney.

As shown by animal studies, STAPHCILLIN is readily distributed in body tissues after intramuscular injection. Of the tissues studied, highest concentrations are reached in the kidney, liver, heart and lung in that order; the spleen and muscles show lower concentrations of the antibiotic. STAPHCILLIN diffuses into human pleural and prostatic fluids, but its diffusion into the spinal fluid has not yet been completely studied. However, one patient with meningitis showed a significant concentration in his spinal fluid while on STAPHCILLIN therapy.

Toxicity studies with STAPHCILLIN and penicillin G in animals show that they have approximately the same low order of toxicity.

Certain staphylococci can be made resistant to STAPHCILLIN in the laboratory, but this resistance is not related to their penicillinase production. During the clinical trials, no STAPHCILLIN-resistant strains of staphylococci were observed or developed; the possibility of the emergence of such strains in the clinical setting awaits further observation.

PRECAUTIONS

During the clinical trials, several mild skin reactions, e.g., itching, papular eruption and erythema were observed both during and after discontinuance of STAPHCILLIN therapy. Patients with histories of hay fever, asthma, urticaria and previous sensitivity to penicillin are more likely to react adversely to the penicillins. It is important that the possibility of penicillin anaphylaxis be kept in mind. Epinephrine and the usual adjuvants (antihistamines, corticosteroids) should be available for emergency treatment. Because of the resistance of STAPHCILLIN to destruction by penicillinase, parenteral *B. cereus* penicillinase may not be effective for the treatment of allergic reactions. Information with regard to cross-allergenicity between penicillin G, penicillin V, phenethicillin (Syncillin) and STAPHCILLIN is not available at present. If superinfection due to Gram-negative organisms or fungi occurs during STAPHCILLIN therapy, appropriate measures should be taken.

SUPPLY

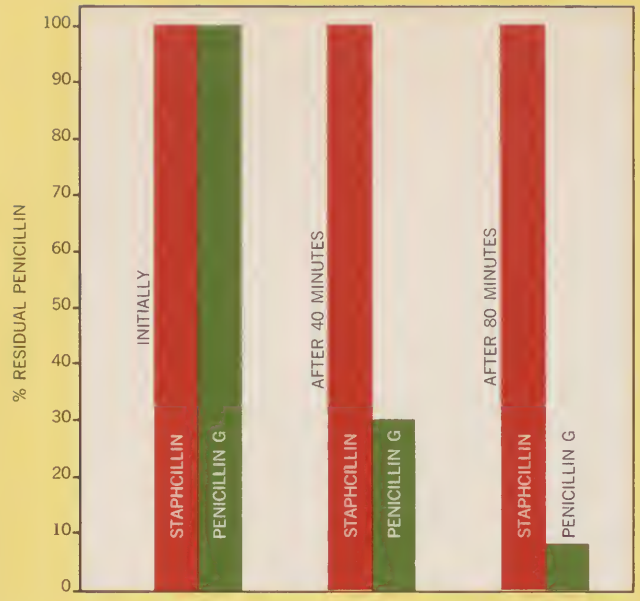
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Specifically for "resistant" staph...

Staphcillin™

sodium dimethoxyphenyl penicillin
FOR INJECTION

The failure of staphylococcal infections to respond to penicillin therapy is attributed to the penicillin-destroying enzyme, penicillinase, produced by the invading staphylococcus.

Unlike other penicillins:

1 STAPHCILLIN is effective because it retains its antibacterial activity despite the presence of staphylococcal penicillinase.

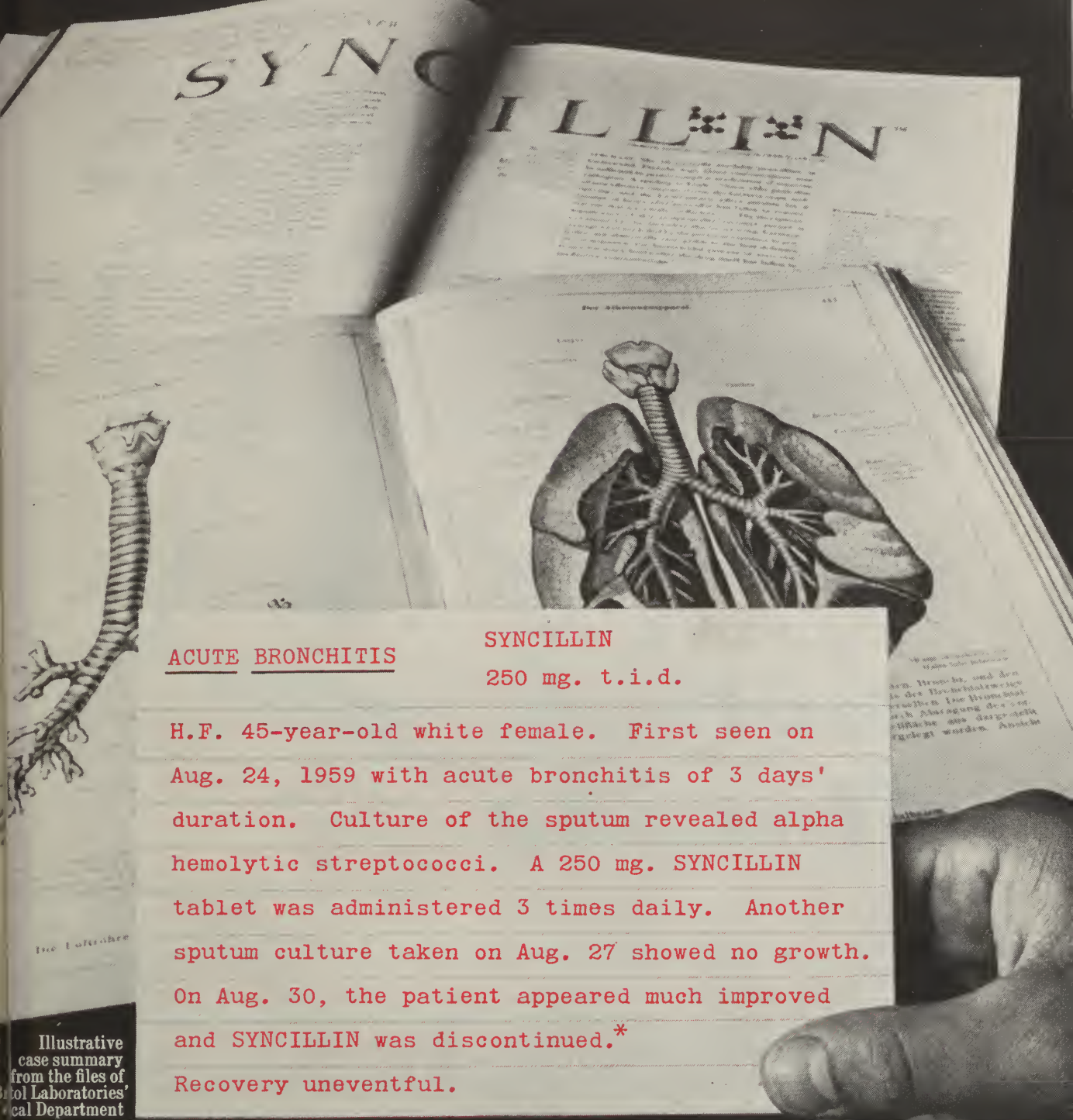
2 The clinical effectiveness of STAPHCILLIN has been confirmed by dramatic results in a wide variety of infections due to "resistant" staphylococci, many of which were serious and life-threatening.

Like other penicillins:

STAPHCILLIN has no significant systemic toxicity. It is well tolerated locally, and pain or irritation at the injection site is comparable to that following the injection of penicillin G. *In occasional cases, typical penicillin reactions may be experienced.*

PROFESSIONAL INFORMATION SERVICE — The attached Official Package Circular provides complete information on the indications, dosage, and precautions for the use of STAPHCILLIN. If you desire additional information concerning clinical experiences with STAPHCILLIN, the Medical Department of Bristol Laboratories is at your service. You may direct your inquiries via collect telephone call to New York, PLaza 7-7061, or by mail to Medical Department, Bristol Laboratories, 630 Fifth Ave., N. Y. 20, N. Y.

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Illustrative case summary from the files of tol Laboratories' cal Department

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Usual dosage for adults and for children over fifty pounds is 250 mg. every six hours.
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Traumatic Rupture Of The Thoracic Aorta

J. ALEX HALLER, JR., M.D.*

Louisville, Ky.

The aortic laceration may be repaired if prompt exploration is carried out. Diagnosis can be made by serial chest X-rays. Decisive surgical intervention is the only successful treatment

THE immediate mortality from rupture of the thoracic aorta is so high that most reports of this injury have come from the autopsy files. Parmley[7] reviewed 296 autopsy cases with aortic injuries resulting from collision accidents. He noted that one out of every seven victims of fatal rupture of the aorta lived longer than one hour following admission to the hospital. A few of these patients lived for several days.

Because of this variable period of delay between rupture and fatal secondary hemorrhage, it is possible that decisive surgical intervention would permit repair of the aortic laceration and alter the miserably low survival figure. This possibility is particularly pertinent since the vast majority of aortic ruptures result from automobile collisions, the incidence of which is steadily increasing throughout the United States.

A few of these patients with minute aortic rents develop late aortic aneurysms;[9, 8, 4, 2] these patients constitute an entirely different group whose therapy will not be included in this disucssion. It is only with the problem of acute rupture of the aorta that we shall primarily concern ourselves in the following report.

Sites of Rupture

Several gross pathological studies are available which document the sites of aortic rupture associated with blunt trauma.[11] As is the case with rupture of the abdominal viscera from nonpenetrating injuries, most lacerations of the aorta are related to points of fixation of the vessel along its course.[5] This is the popular theory of shearing stress which has been widely accepted. As shown in Figure 1, the most frequent site of rupture of the thoracic aorta occurs just distal to the left subclavian artery. The next most common site is the ascending aorta but this injury is usually associated with a crushing or compressing type injury of the chest rather than the much more common deceleration or collision accident.

In 1944, Haas,[12] first proposed another factor to account for deceleration rupture of the aortic isthmus. His theory proposes that the inertia of the various tissues is directly related

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to their density and that therefore, rupture at this site is on the basis of sudden forward displacement of the descending aorta, a type of vascular whip lash injury. This explanation is illustrated in Figure 2. Perhaps the best evidence that this is an important factor in localization of rupture is the fact that most lacerations of the aorta at this site occur in the posterior wall of the aorta.[10]

Present surgical techniques, including multiple blood transfusions and adequate anesthesia for intra-thoracic procedures, render a surgical attack on this problem possible with an acceptable risk. The chief obstacle to surgical intervention in these cases has been the failure to diagnose the lesion early enough to permit definitive surgery. Many of these patients have complex multiple injuries, often serious orthopedic emergencies, including compound fractures and multiple soft tissue injuries, which are so obvious that the hidden injury of fatal nature within the intact chest is overlooked. The apparently normal chest with its 1 or 2 rib fractures gives a false sense of security when it may hide the lethal mischief within.

Diagnosis

The slim chance of recovery from traumatic rupture of the thoracic aorta is therefore dependant upon a high index of suspicion of this injury in all patients who have been involved in high velocity automobile accidents and who have any signs or symptoms suggestive of chest trauma. Many of these patients complain of slight shortness of breath and pleuritic pain but a few have severe, compression type chest pain and marked symptoms from the enlarging mediastinal hematoma. Except for evidence of associated rib fractures and an occasional hemopneumothorax, the physical examination is usually unrewarding. An immediate chest x-ray is the best single diagnostic procedure.[13]

Widening of the superior mediastinum is strong presumptive evidence of a mediastinal hematoma. This is particularly significant if serial x-rays reveal a progressive widening of the mediastinal shadow. A delayed hemothorax[7] is also significant but it usually heralds free rupture of the contained mediastinal hematoma into the pleural cavity with a rapidly fatal outcome. Retrograde aortography has been helpful in those few patients in whom fatal hemorrhage is delayed for several hours. The diagnosis is at best only presumptive in most cases but unless these patients are operated upon with dispatch, this disastrous lesion will continue to be overlooked.

Specific Problems

A number of specific problems are encountered at the time of the emergency thoracotomy in such patients aside from those usually associated with thoracotomy in the patient with multiple injuries. The first of these is the huge pulsating hematoma filling the anterior-superior

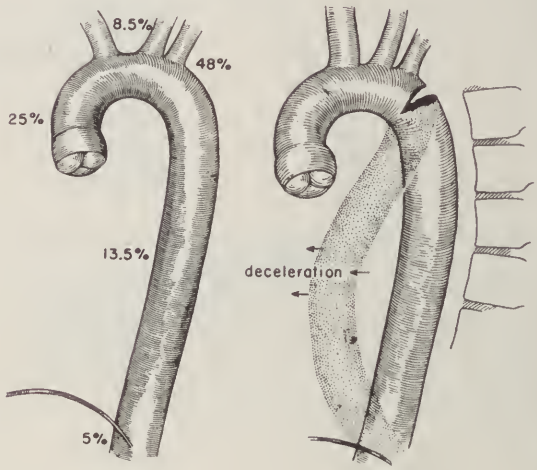


FIGURE 1 FIGURE 2

Fig. 1. Sites of rupture of the aorta.

Fig. 2. Mechanism of traumatic rupture of thoracic aorta. Note posterior location of initial tear from deceleration forces.

mediastinum. All normal planes of dissection are usually obliterated. The principal of proximal and distal control of the aorta is of paramount importance and must be the first order of business. Because there has been no time for the development of collateral circulation, interruption of the aorta at this level is followed by serious spinal neurological damage and often renal damage as well if the period of occlusion is longer than 10 or 15 minutes. To extend this period for adequate dissection and plastic repair of the aorta, either an aortic by-pass graft or full hypothermia has been useful.

The complexities of hypothermia in the seriously injured patient have about rendered it obsolete in most medical centers.[1] The preferred method of maintaining distal perfusion is a prosthetic by-pass from the proximal to the distal aorta as a temporary shunt.[3] Once the



Fig. 3. Chest X-ray in case 2 showing slight widening of mediastinal shadow.

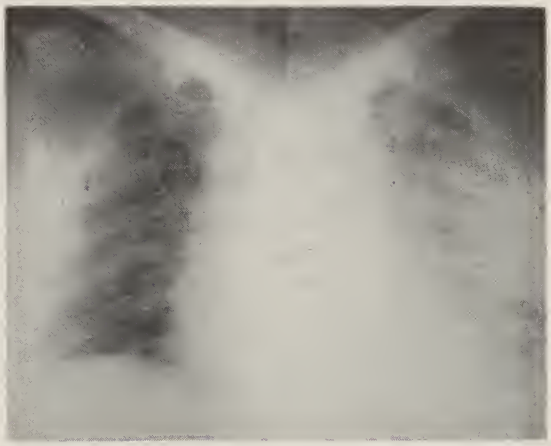


Fig. 4. Later X-ray in case 2 with progressive widening of mediastinum.

by-pass is instituted and the aorta cross clamped above and below the rent, the actual handling of the laceration and the aortic reconstruction is not difficult. If the vessel is badly damaged, a vessel prosthesis can be employed or if the rent is small, direct suture of the laceration can be carried out.

Illustrative Cases

The following patients illustrate the problems in diagnosis and treatment of patients with traumatic rupture of the thoracic aorta. These patients were all operated upon at the Johns Hopkins Hospital with Dr. Henry Bahnson and Dr. Frank Spencer.

CASE 1: The first patient was a 30-year-old semi-professional baseball player who was brought to the emergency room shortly after a single car collision with a large apple tree. He was semi-comatose on admission but became combative in the emergency room. He complained of some anterior chest pain and had multiple lacerations of the face. A chest x-ray revealed undisplaced fractures of the 3rd, 4th and 5th ribs on the left posteriorly. There was slight widening of the mediastinum which was, in retrospect, all important. Following several hours in the emergency room, the patient became progressively more uncooperative and finally signed out against medical advice. He was discovered at home dead in bed 12 hours later.

The coroner's examination revealed a complete transection of the thoracic aorta just distal to the left subclavian artery. It was this



Fig. 5. Final X-ray in case 2 with left hemothorax secondary to rupture of mediastinal hematoma.

case which prompted a discussion between the coroner of the City of Baltimore and our cardiovascular surgical team concerning this lesion, its pathogenesis, and possible treatment.

Shortly thereafter the second case was admitted to the emergency room.

CASE 2: This was a 32-year-old white male whose convertible ran against a culvert in Baltimore County. He had a compound fracture of the right femur, complained bitterly of chest pain and marked shortness of breath. There was slight hemoptysis and some depression of breath sounds over the left chest. X-ray revealed fractures of 5 ribs posteriorly on the left. The first chest x-ray is shown in Figure 3 with moderate widening of the mediastinum. While under observation in the accident room a repeat x-ray was taken 4 hours later which showed progressive widening of the mediastinum. (Figure 4) He was taken to the recovery

room for observation and blood replacement. Shortly after arrival he developed sudden paralysis from the hips down. It was noted that he had no femoral pulses and no sensation below the nipple line. Figure 5 shows the 3rd x-ray taken at this time, 11 hours after his admission to the emergency room. There was a secondary hemothorax.

He was taken to the operating room, 12 hours following his admission. During induction of anesthesia cardiac arrest occurred. The left chest was opened rapidly and was found to be filled with fresh blood. This was quickly aspirated and cardiac resuscitation attempted. This was unsuccessful because of inability to control the massive hemorrhage from the large mediastinal hematoma. There was a nearly complete transection of the thoracic aorta just below the left subclavian artery. There was a short area of dissection[6] with complete obliteration of the lumen of the aorta distal to this transection. This occlusion accounted for his neurological deficit and for the absence of distal pulses. This aortic lesion could have been handled easily if an earlier decisive approach had been used.

CASE 3: The final patient is a 24-year-old white boy who was brought to the emergency room following a high velocity automobile collision. He had a forearm fracture, some facial lacerations and slight shortness of breath on admission. The chest x-ray revealed slight widening of the mediastinal shadow but this was not very striking. While under observation in the recovery room, a repeat x-ray showed a slight increase in the mediastinal shadow. He was operated upon 16 hours following his admission to the emergency room on the suspicion that a traumatic rupture of the thoracic aorta had occurred. On opening the left thorax, a huge hematoma was present in the mediastinum. Proximal and distal control of the aorta was rapidly obtained. Large Teflon catheters were inserted into the aortic arch and the distal thoracic aorta and a DeBakey type pump used as the propelling unit to perfuse the distal aorta. The aorta was cross clamped for 30 minutes while the almost complete transection of the aorta was identified, the lacerated segment resected and a Teflon graft inserted across this defect. The patient made an eventful postoperative recovery and has been back at work now for 11 months.

Summary

Traumatic rupture of the thoracic aorta may result from deceleration forces in highway collisions. This injury has a very high immediate mortality. The occasional delay between formation of the mediastinal hematoma and final exsanguinating rupture may permit repair of the aortic laceration if prompt exploration is carried out. A high index of suspicion is mandatory in all patients with thoracic injury associated with high velocity accidents. Only by decisive surgical intervention can this otherwise lethal lesion be treated successfully.

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The Primary Repair Of Soft Tissue Injuries Of The Face

ANDREW M. MOORE, M.D.

Lexington, Ky.

Awareness of the function of parts and the ability to assess over-all needs are required, as well as an understanding of the type of injury and technique of repair

WHILE the face may not be man's fortune, the proper function of its components certainly play a major role in life. Of these various parts, the soft tissues are most important. Upon their integrity depends protection of sight, ability to speak, to hear, to masticate, to express oneself, and to maintain the vitality of the underlying skeleton. In addition, there is a less tangible but quite real consideration, that of appearance itself. All people are susceptible to first impressions and this, to a great extent, is formed by our calling card, the face. For example, such words as sly, wicked, kindly are often used to describe the countenance. Certainly the "good guys" on television have a standardized acceptability about their faces.

When the soft tissues of the face are injured, it is imperative that a thoughtful and carefully planned repair be carried out. This applies not only to the more severe and complex injuries created by our automobiles, but also to those common hurts encountered every day in the emergency room. Too often, a cursory or indifferent attitude is assumed with results that are an embarrassment to the surgeon and repugnant to the individual. Proper soft tissue repair is the "sine qua non" of surgery.

My own initial experience in this field, I sadly fear, is quite typical. As a junior medical student, assigned to surgery for the first time, I was told offhandedly to "sew up" a small laceration of the face. To me, at that time, matters of technique were vague terms I had heard the professors profoundly discuss while I half listened. After an hour of horrible and trembling uncertainty, the patient was released with an inferior repair and sloppy dressing, but with considerable more equanimity than I could muster. It would have been better if I had been guided through this ordeal, as happily later occurred, thereby avoiding much unpleasantness for two poor souls.

This simple, yet vital, procedure is too often casually assigned to the tyro without realization that the undertaking is the most fundamental and important aspect of surgery. Factors enter into the repair of wounds over which we can exert no influence, making it mandatory that we put forth every effort to do our part correctly.

Overall Appraisal

The first step toward this goal is the overall appraisal of the patient. An adequate airway must be assured, shock treated by appropriate measures; the presence and degree of associated intracranial damage, or remote injury determined. The need for tetanus prophylaxis and appropriate antibiotic treatment must be recognized. It may be desirable or necessary to postpone definitive treatment if such will jeopardize the total welfare of the patient.

Repair may be safely deferred, when indicated, for many hours and, occasionally, it is

*Presented at a meeting of the Kentucky Surgical Society, French Lick, Indiana, on May 14, 1960.

mandatory that it be put off indefinitely. In these instances, careful toilet of the area, a few well aligned directional subcutaneous sutures, and a protective dressing will lead to primary healing and avoid further damage. More often than not, after careful assessment, repair at least in some degree may be done.

When attention is turned to the facial injury itself, it is helpful to recall the nature of the various types of wounds. An abrasion is the result of friction; a variable thickness of the skin is rubbed off. These may, on occasion, represent full thickness skin loss and are very similar to burns in their behavior. Contusions are the result of blunt force with rupture of the underlying vessels which may devitalize the overlying tissue by the pressure of hematoma formation. A laceration is a wound made by tearing. An avulsion is characterized by loss of substance. A simple incision is rarely seen. Most often, soft tissue injuries are combinations of these, particularly lacerations.

The principles of soft tissue repair are based on the wisdom of the ages. The list of illustrious surgeons, who have conceived those precepts which we all know and frequently ignore, is quite familiar. The Golden Rule might well be: "Do unto the tissues as you would have done unto you."

Techniques

The objective is to achieve primary wound healing. This minimizes undesirable fibroplasia and requires that infection and edema be controlled. Aseptic gentleness in handling the tissues is the single most important factor. This is facilitated by manipulation of the injured area thoughtfully, using small instruments and fine suture material. Skin hooks are far less damaging than thumb forceps, and it is more difficult to produce tissue ischemia with readily broken 6-0 suture than 2-0.

The area must be carefully cleansed with soap and water, protecting the wound itself from further soiling. Strong antiseptic solutions are avoided. Foreign matter, debris, and necrotic material are painstakingly removed and the wound washed gently with saline. Where dirt has been ground into the area, it must be picked, scraped, or even scrubbed out. If not, an unpleasant traumatic tattoo invariably results. Hemostasis must be meticulous. Bleeders are carefully picked up and tied with very fine ligatures, usually of catgut.

This carries us up to the moment of truth; the decision as to how definitive we can safely be. It is dictated by the patient's general condition and the extensiveness of the facial injury itself. No evaluation is complete if the integrity of other contiguous structures is not assessed. The eyes must be carefully examined and have priority in any repair. The function of the facial nerve is ascertained and the condition of the parotid and lacrimal ducts should be known.

Simple lesions may be repaired in the cooperative patient in the emergency room with local anesthesia rather than hazard a general anesthetic with the patient's stomach, as it invariably is, full. More extensive reconstruction should be undertaken in the operating room and, for accomplishment in the young or those requiring other surgical attacks, general anesthesia may be needed.

Definitive Repair

If definitive repair is to be done, devitalized tissue is sharply trimmed away. Indeed, the entire wound may be excised. However, because of the critical need for every portion of the skin envelope of the face, preservation of all viable tissue is desirable. If this is not done, distortion of adjacent structures may occur with damage to function. The frequently encountered beveled wound or "trap door" flap, is best excised and the edges undermined for closure, for even when sutured most carefully, elevation of the undercut skin occurs during healing. This produces an unsightly scar. Unhappily, the overall picture frequently prevents extirpation, as the immediate sacrifice of the tissue or time required will be too great and final correction must be relegated to a later secondary procedure.

The contour and expression of the face are dependent upon certain lines which run, in general, perpendicular to the muscles of expression. These must be respected by the surgeon, if not by the injury. Fortunately, the marvelous blood supply of this region often sustains us and permits transposition of flaps to break up wounds across these flexion creases.

Having created, to the best of our ability, a clean surgical wound with perpendicular edges, the area is again washed and, if necessary, re-

draped. Meticulous closure is carried out. It is best to obtain apposition of the tissues with small subcutaneous sutures so that no dead space remains and few skin sutures are needed. Wound edges are aligned by starting from the known anatomical landmarks and approximating the tissue with evenly spaced sutures or, at times, bisecting the wound progressively. The skin sutures should be placed within one or two millimeters of the wound edge and perpendicular to it. They should be loosely tied. No area should be left uncovered and, where undermining or the shifting of local tissues will not suffice for closure, there should be no hesitation in using either full thickness or split skin grafts.

The facial nerve, if severed, may be re-approximated with fine silk; the cartilages of the lids, ear, nose with fine catgut through adjacent tissue. The parotid duct may be closed over polyethelene tubing sutured in place or the proximal end of the duct tacked to the mucous membrane of the mouth. The same material passed through the puncta of the injured lacrimal duct, through the lacrimal sac, and into the nose, serves as a splint over which repair may be done. In the nose it can be grasped, pulled out, and tied or sutured to itself. No qualms should be experienced in closing oral wounds and the most comfortable results occur when submucosal sutures are used.

Dressing

The proper application of a dressing is an absolute necessity. The injured parts must be supported and placed at rest. This minimizes tension on the area and the production of edema. The lytic enzymes may be of help in controlling swelling. If the eyes are to be covered, they are washed out with saline, and a bland ophthalmic ointment instilled. Fine mesh gauze is placed over the wounds. These are smoothly overlaid with gauze flats. Contours are filled out with mechanics waste or fluffs, and a massive firmly fixed pressure dressing applied. To obtain this, in many instances, a wrap-around affect is needed, using kerlix rolls reinforced with roller bandages or kling.

The dressings are changed on the second or third day. Sutures are removed if the condition of healing permits. This further minimizes the cross-hatching which may occur. The area may be reinforced with collodion gauze strips or adhesive and an adequate dressing reapplied. Wound support should continue for 10 to 21 days, depending on the extent, nature and appearance of the healing wounds.

At times, for many reasons, what was hoped and striven for cannot be attained. It is an immutable fact that wounds heal by scar formation. Further, in given situations, compromise may be forced upon the operator. It is well to recognize this unpleasant fact. Careful explanation of the problems and expected results, both to the patient and his family, avoids disappointment. This, coupled with the knowledge that, at a future date, improvement may be had with secondary procedures, is reassuring and comforting.

Summation

In conclusion, it may be stated that the appropriate primary repair of soft tissue defects of the face, is the ultimate test of fastidious surgical judgment and technique. Many circumstances determine the degree of success achieved, but certainly, understanding of the nature of the injury and strict adherence to well-known principles are mandatory for the surgeon. The greatest reward is the satisfaction of passing this demanding surgical trial with flying colors.

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Mandl And Albert

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A chronicle of the dramatic and successful removal of the first parathyroid adenoma by a young surgeon, establishing the clinical entity of 'hyperparathyroidism' 35 years ago

Scant attention, outside of close friends and co-workers, was directed to the October 16, 1957 death notice of one Dr. Felix Mandl of Vienna.[1] However, it is to this physician that one thousand or more, past and present, sufferers of hyperparathyroidism have been grateful for restoration of their health. This is his story.

Following Von Recklinghausen's description of osteitis fibrosa cystica in 1891,[2] the significance of the little brown neck tumors (parathyroids) in these cases had escaped recognition, though commented on by others. Actually, Von Recklinghausen himself did not recognize the little brown tumors as being parathyroid glands. For a number of years that followed, the only knowledge about the parathyroids was the fact that destruction of these glands led to tetany (Gley) and that experimental tetany could be relieved by transplantation of parathyroid tissues (Von Eiselberg).[3]

However, MacCullum and co-workers in the United States were soon to demonstrate the correction of parathyroid deficiency tetany by the administration of calcium.[3] Likewise, Jacob Erdheim, the eminent Viennese pathologist, in a brilliant study proved that the crumbling teeth in parathyroid deficient rats was due to lack of calcium and the link between calcium, bones, and parathyroids was forged.[4] This pathologist went on to describe the enlarged parathyroids in osteomalacia and correctly assumed that this was a compensatory enlargement. It was only natural that most physicians then reasoned that enlargement of the parathyroids, in Von Reckinghausen's disease, was a secondary attempt by the body to mobilize calcium to the cystic bones.

As a consequence, the concept of primary hyperactivity of the parathyroids resulting in cystic bones and/or urinary calculi was not considered at this time. Likewise, it was not until several years later that Dubois,[5] Albright and co-workers[6] were to demonstrate the classic triad of hypercalcemia, hypophosphatemia and hypercalcuria occurring in hyperparathyroidism.

Albert

It was into this setting in Vienna there hobbled a street car conductor named Albert. This unfortunate advanced case of osteitis fibrosa cystica was admitted June, 1925, to the Eiselberg Clinic.[7]

The patient was a 37-year-old white male. Past history revealed that at 19 years of age he had been diagnosed as having syphilis. Apparently he was treated and recovered without any undue sequelae. He served in World War I in the Austrian Army under the Emperor Franz Josef, but was discharged in 1918 because of pulmonary tuberculosis. After treatment, this became arrested and played no role in his subsequent medical history.

In 1920 he sustained a fracture of his clavicle when he fell upon his outstretched arm. This healed without difficulty, but at this time he began to complain of easy fatigue, weakness and pains in his pelvis and lower extremities. Apparently he traveled from clinic to clinic, spa to spa and suffered many, many varied forms of treatment all to no avail. His disability became so complete that he was pensioned as disabled by the government.

*Presented to the Innominate Society, Louisville, Kentucky on March 8, 1960.

By 1923, poor Albert was in a terrible state and his condition was deteriorating rapidly. X-rays, at this time, showed osteitis fibrosa cystica involving the pelvis, femurs and tibias. In December, 1924, he sustained a spontaneous fracture of the left femur, which healed uneventfully. The significant appearance of white gravel in his urine was noted by the patient. Following this he had further weight loss and weakness. At the time of admission, actually, Albert could hardly stand and his pelvis seem to give with standing and walking. He was called a "jellyfish" by his examiners. His legs bowed forward and he exhibited marked dorsal scoliosis of the spine. Likewise, he had a rachitic rosary of his chest. The thyroid was noted to be small. His deep reflexes were diminished throughout, the weakness of all muscle groups was noted.

News apparently had reached Vienna of the discovery in 1925 by Collip and Hanson of the active principle of the parathyroid gland, as Albert was treated with parathyroid extract. This treatment was of no avail, and if anything he became worse.

At this seemingly hopeless stage, there appeared on the scene a young surgeon, Dr. Felix Mandl, and he assumed control of Albert's case. Who was this surgeon and what were his qualifications?

Mandl

Felix Mandl was born in Brunn, Germany, in 1892, the son of an industrialist. Preliminary schooling was acquired at Brunn until 1910 when he matriculated at the University of Vienna, working towards his medical degree. The advent of World War I interrupted his studies, and the young student enlisted in the Austrian Army of Emperor Franz Josef, serving at the front from 1914 to 1918. Following the cessation of hostilities, he returned to Vienna and received his long awaited medical degree in 1919. Surgery attracted this promising physician and he promptly embarked on a course of training in this specialty. Studying under Hochenegg at the Second University Clinic of Vienna, he attained the rank of surgeon in 1923.[8] There is no record of his career after 1923, but it is assumed that he became a surgical staff member of Eiselberg's Clinic, for it was at this institution that his and Albert's paths crossed.



Figure 1

Felix Mandl

Having been influenced by the noted pathologist, Erdheim, young Mandl must have believed that the syndrome of osteitis fibrosa cystica was due to some intrinsic calcium defect in the osseous system and that the parathyroid gland enlargement was a compensatory attempt to mobilize blood calcium for the bones. As a consequence, when confronted with the sad plight of Albert, he suggested transplantation of parathyroids to further aid in re-calification of the cystic bones of the poor street car conductor.

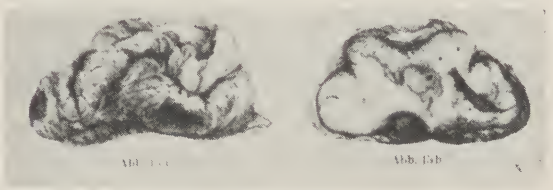


Figure 2

Mandl's efforts were rewarded when he found a tumor lying in the branches of the inferior thyroid artery. (Reprinted—Arch. f. klin. Chirurgie v.143: 256, 1926)

The Surgery and Results

When a suitable fresh accident death case arrived at the hospital, Dr. Mandl removed four parathyroid glands and implanted them into the pro-peritoneal space of his famous-to-be patient on July 2, 1925. As one would expect, there resulted no improvement following the transplantation. The young surgeon apparently reasoned that the opposite theory, favoring disease or dysfunction of the parathyroid as being causative in Von Reckinghausen's disease, was possibly correct.

There are no details as to how exactly he arrived at his decision, but, at any rate, he elected to operate and search for an abnormal parathyroid. Whereupon with boldness, tempered with some desperation, Mandl under block anesthesia explored the left neck on July 30, 1925. His efforts were rewarded with success when he found a 25x15x12 mm. tumor

lying in the branches of the inferior thyroid artery on the left between the trachea and the esophagus (see Fig. 2).[7] This he removed completely and submitted it to the old professor, Erdheim, for microscopic examination.

The pathologist accommodated the surgeon and confirmed that this was a tumor or adenoma of the parathyroid gland. His microscopic report described a typical epithelial body with plexiform strings, meshed together and separated by small strands of connective tissue which contained few cells. The epithelial cells were almost colorless or clear (as water) with a free nucleus and arranged in a mosaic pattern. There was no normal parathyroid tissue. This description was that of a clear cell adenoma. The battle had been won (or nearly so); Albert and Mandl were soon to be famous as a team.

Albert manifested remarkable improvement and within six days his urine sediment had cleared. By the end of August, 1925, his pains were markedly reduced and in September he could walk and stand with the aid of crutches. In December of 1925, it was Dr. Mandl's pleasure to report his case and demonstrate his prize patient to the Vienna Medical Association.

This case presentation included demonstration of pre- and post-operative x-rays, showing significant improvement in the cystic bones. The only lab studies listed were a pre-operative quantitative urine calcium of 54 mg per day compared with the post-operative quantitative urine of 7.6 mg per day (11th post-operative day). There was no record made of blood calcium or phosphorus determination.

Albert enjoyed good health for six years following removal of the adenoma and his skeleton re-calcified. Alas, in 1932 his old symptoms recurred and with such severity that Mandl felt that he probably had another adenoma. Accordingly, he re-explored the neck in 1933 in a futile attempt to find another parathyroid adenoma. There is no record, but it is assumed that Albert's course was gradually down hill because he died in 1936 of uremia, probably due to advanced renal pathology. A post-mortem was carried out, and to the credit of Dr. Mandl, there was nothing to suggest another parathyroid adenoma or evidence of hyperplasia.

Mandl's Later Life

As if the death of Albert was a premonition of troubles ahead, the brilliant career of Dr. Mandl was soon to be put in jeopardy by the black cloud of Nazism which rolled over his native land. In 1938, while serving as the director of the Canning Child Hospital and Research Institute of Vienna, he was obliged to leave the country and seek asylum in Jerusalem. In that country, he was immediately engaged to head the surgery division of the Hadassah University Hospital. In this atmosphere he resumed his studies. Following the end of World War II he returned again to Vienna and assumed direction of the Franz Josef Hospital in Vienna, where he directed restoration of the badly damaged institution. His lectureship was renewed in 1947 and his appointment as an Associate Professor of Surgery was accompanied by reports of his many surgical studies, totaling some 300 contributions to the world literature. To this surgeon was accorded the honor title of a Master of Surgery, in addition to other honors from medical organizations and schools. In recognition of his long devotion to the field of surgery, he was chosen to serve as vice-president of the International College of Surgeons.

Following a bout of "grippe," he died of a heart attack October 16, 1957. It is, indeed, ironical and sad that his death preceded by just one month the publication of the November 1957 Journal of the International College of Surgeons which was prepared as a special issue in his honor.[8]

The untimely death of this outstanding, yet humble, surgeon rang down the curtain on one of the fascinating medical histories—the story of Mandl and Albert.

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Management Of Chronic Urinary Tract Infections In Children*

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Pediatric urinary tract infection is common, often asymptomatic. Suspect structural disease in boys or with recurrence in girls. Microscopic urinalysis and urine culture required

THE management of chronic urinary tract infection is our most common pediatric urological problem. It is an important condition, easy to overlook, and its sequelae are potentially disastrous if it continues to progress as the child matures into an adult. Surgery frequently is required to correct major urinary tract abnormalities but the purpose of this paper is to discuss the medical management of those patients without a surgical lesion, or one which could not be completely corrected.

Both Jackson and his co-workers and Sanford recently have emphasized the insidious onset of chronic pyelonephritis in adults, presenting, at the time the diagnosis is made, either no history of symptomatic pyelonephritis or one of apparent unrelated attacks in childhood and early adult life. It seems obvious, therefore, that the earlier and more completely the disease can be eradicated, the better the ultimate prognosis will be.

We have preferred the term urinary tract infection in children rather than cystitis or pyelonephritis because of the difficulty of differentiating between infection confined to the bladder, and that involving the kidneys as well. In some cases renal infection may be discovered by culture of urine samples collected from the kidneys when only bladder infection was clinically suspected.

Diagnosis

In children, as in adults, the diagnosis of chronic urinary tract infection may be difficult to establish since many chronic infections may be accompanied by few symptoms. Conversely the acute hemorrhagic variety is easily recognized and has seldom been difficult to control. Obviously, there are numerous children with undiagnosed urinary tract infection.

The discovery of urinary tract infection is made even more difficult by its characteristic intermittent exacerbations followed by quiescent periods when diagnosis may be impossible. Unfortunately, it seems that the disease can progress during these apparently inactive periods.

The only way to detect these relatively asymptomatic infections is by routine urinalysis, sediment smear microscopy and bacteriologic culture of the urine of all children who show any indication that they are not well. When discovered, a complete urologic investigation should be carried out, for the urinary tract in children is a frequent site of congenital and obstructive lesions that may be manifest only by infection. Such investigation includes cystoscopy, cystography and pyelography and cultures of urine collected from the bladder and kidneys.

We concur with the belief of other observers

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that recurrent urinary tract infection in a clinically unobstructed urinary tract is not a series of isolated episodes. These exacerbations have been most logically explained as reinvasion, or reactivation of temporarily non-pathogenic bacteria present in the urinary tract. Micro-obstructive changes within the nephron caused by previous inflammatory changes may contribute to the frequency of recurrence.

Therapy

The best ultimate prognosis would be dependent upon early eradication of the disease. A short intensive course of therapy is effective for acute exacerbations of chronic urinary tract infection but often does not affect the underlying disease. Therefore, for such patients, in whom a quick, complete cure is impossible, a prophylactic regimen of therapy is indicated. This should discourage the recurrence of infection while the patient has a chance to develop greater resistance to infection. This therapy could be compared to the prophylactic treatment of patients whose acute exacerbation of a rheumatic fever has been controlled.

Many antimicrobial drugs now available for treating acute exacerbations of urinary tract infection are effective. However, penicillin and other antibiotics effective only against cocci, are rarely of value since this type of organism is seldom responsible for urinary tract infection. Other antimicrobials such as Altafur® have a low concentration in the urine.

The antimicrobials available for prophylactic administration are more restricted. Antibiotics have little value prophylactically because they often tend to permit the development of drug resistant bacterial mutants. These drugs also have occasional intrinsic toxicity which contraindicates their prolonged use routinely. The sulfonamides have long been known to be effective against E. coli and Addis quite a few years ago popularized their use prophylactically. In our experience Gantrisin® has proved to be safe and occasionally effective. Furadantin® was selected for further study because of its apparent wide range of antibacterial action and because earlier studies by ourselves and others indicated non-toxicity and less tendency for bacterial resistance to develop. We felt, therefore, it should be well suited for both prophylactic and therapeutic use.

Material and Method

This paper is based upon a review of a group of 121 children with chronic urinary tract infection treated with Furadantin. They were followed for a period of from 1 to 6 years. (Table I) We feel that a year is a minimal period of time to evaluate the disease and, therefore, patients followed for shorter periods were not included in this study.

Twenty-four of the patients in this series had either a major urinary tract anomaly that could not be completely corrected by surgery, or dysfunction due to neurogenic disease. We classified these patients as having complicated urinary tract infection. Ninety-seven patients were classified as uncomplicated, although this group included those with minor urologic abnormalities, such as vesicoureteral reflux without hydronephrosis or hydroureter, cystitis cystica, and mild urethral stricture. The higher incidence of the disease in little girls is reflected in this series. We have administered Furadantin for a prolonged period of time in many children. Eighty-five patients received Furadantin for more than six months and 26 for more than two years.

TABLE I
Duration of Treatment

	Uncomplicated Urinary Tract Infection	Complicated Urinary Tract Infection
Total patients followed more than 1 year	97	24
Boys	6	9
Girls	91	15
Patients followed more than 3 years	39	12
Patients who received Furadantin for a period of more than 6 months	65	20
Patients who received Furadantin for a period of more than 2 years	14	12
Patients receiving Furadantin at time of report	30	13

In the last several years a prophylactic regimen has been used for at least three months after bacteriologic control of infection in uncomplicated cases. A therapeutic dosage of 6 to 10 mg. per kg. of body weight per day was used and a prophylactic dosage of from 1 to 5 mg. per kg. administered for as long as five

years. The follow-up examinations included clinical observation, urinalyses, urine cultures, periodic blood examinations and further urologic studies when indicated.

We found urinalysis and urine culture to be the most important items in the follow-up because they were frequently the only indication of persistent disease. The services of a dependable bacteriological laboratory are essential in the care of these patients because the importance of bacteria in the urine depends upon the type and number of organisms present.

Bacteria signifying persistent infection may be revealed by culture when the urinalysis is normal. A growth of pyogenic bacteria on a blood agar plate inoculated with two drops of urine was considered significant. Pyogenic organisms present only in the broth culture were considered significant when they were the same as those recovered during clinical infection. About 90% of the infections were caused by bacteria of the coli and proteus species. Infection due to multiple organisms and a change of organism during treatment were frequently encountered.

TABLE II
Results of Furadantin Treatment

	Uncomplicated Urinary Tract Infection	Complicated Urinary Tract Infection
Controlled without recurrence	34	5
Controlled, but recurred and recontrolled at time of report	58	10
Not controlled at time of report	5	9

Catheterizations have been done either by myself or my associate. Usually the children are very cooperative when properly approached. I believe it is justifiable to consider small numbers of bacteria significant when the cultures are obtained under such conditions. In our hands catheterization rarely introduces infection.

Results

The results of this review were similar to those we have previously reported and those reported by Lippman, Wrobal, Rees, and Hoyt. (Table II) As a result of our observations we feel that the surgical correction of major urinary abnormalities continues to be an essential part of treatment. It cannot be replaced by antimicrobial therapy. While Furadantin administration seemed clinically helpful to some patients, we failed to achieve more than transient sterilization of the urine in patients who had a foreign body in their urinary tract or who following repair of extrophy of the bladder voided from a rectal reservoir separated from the fecal stream by colostomy.

Twenty-four of the patients in this series had either a major urinary tract anomaly that could not be completely corrected by surgery, or dysfunction due to neurogenic disease. We were able to control the infection in more than half of these patients although they have required long periods of Furadantin administration. More than half of these patients were receiving therapy at the time of the report and almost all of them required more than six months of treatment.

97 Classified as Uncomplicated

Ninety-seven were classified as uncomplicated, although this group included those with the minor urologic abnormalities previously reported. While the incidence of recurrence was markedly reduced, an exacerbation of infection occurred in more than one-half of the patients when treatment was discontinued.

In a number of cases infection has been recontrolled in patients taking a small prophylactic dose of Furadantin simply by increasing the dosage to a therapeutic level. A few patients whose infection was initially resistant to all antimicrobials were controlled by a therapeutic dosage for a period of more than three months. The maintenance of a sterile and antiseptic urine apparently allows the renal, ureteral and bladder structures to overcome the effects of infection and explains the effectiveness of Furadantin, even though its tissue concentration is low. Since recurrences have increased with the time the patients were followed, the actual incidence is undoubtedly still higher than that which we have reported.

This emphasizes the need for a prolonged prophylaxis and follow-up examinations before eradication of the disease within the structures of the urinary tract can be expected. The length of prophylactic therapy needed to maintain a

sterile urine is reflected by the two-thirds of the patients who have received Furadantin for more than six months. Indeed for about 15% of these patients prophylactic Furadantin therapy was required to maintain a sterile urine.

The results of therapy in those with vesicoureteral reflux without hydronephrosis or hydroureter are apparently similar to those without reflux. (Table III) Similarly cystitis cystica and mild urethral strictures did not seem to alter the results of treatment significantly. However, patients with reflux and cystitis cystica have received a longer period of therapy. Of course, the urethra was dilated in those patients with stricture and in a few cases the cystitis cystica was fulgurated. When infection was controlled reflux frequently improved or disappeared. Cystitis cystica disappeared in some patients following treatment.

TABLE III

Correlation of Reflux with Results of Treatment

Reflux Present	Number of Patients	Controlled without Recurrence	Controlled with Recurrence	Not controlled at report
Yes	24	6	17	1
No	23	3	18	1

In the eight patients tested for the presence of hypogammaglobulinemia, normal values were obtained.

Furadantin was found to be well suited for this treatment of chronic urinary tract infections that do not require surgery. It was found to have a wide range of antimicrobial effectiveness suitable for both therapeutic and prophylactic use. No significant toxicity was encountered. It is a valuable adjunct in the treatment of children with neurogenic bladders and incompletely relieved obstruction. The prophylactic value of the drug is enhanced by the lack of any significant tendency to develop drug resistant bacteria mutants.

We have confirmed that young girls do "grow out of" urinary tract infection, for it is rare to encounter an initial attack in a teenage girl. None of our patients who are now in their teens, who had an uncomplicated infection initially, now have active infection, evidence of reduced renal function or abnormal urinalyses. This observation does not lessen our obligation to see that these patients overcome their disease without residual damage that may make them renal cripples when they are adults. Since infection occurs so much more frequently in girls than boys, it would seem probable that the length and structure of the urethra plays a major role in the etiology of this infection. While poor perineal hygiene has been reported to play a role in infection and if present should be corrected, it did not appear to be significant in this group of patients. Infection in boys should alert the clinician to suspect a complicating surgical condition.

Treatment Plan

As a result of these observations we have developed a general plan of treatment to follow our urologic investigation. Those patients with uncomplicated chronic urinary tract infection receive a therapeutic dose of Furadantin, 6 to 10 mg. per kg. of body weight daily, for a period of at least two weeks. If the urinalysis and bacteriologic culture at completion of this course of treatment show no evidence of infection the dose is reduced by one-third to one-half and the medication continued at this level for a period of at least three months. If two weeks' treatment with Furadantin fails to control infection, we try to find another antimicrobial drug to which the organisms are more sensitive. If the organism seems resistant in vitro to all antimicrobials, Furadantin is continued at its maximum tolerated dosage for at least six months. Urinalyses and urine cultures are carried out about two weeks after the medication is discontinued, and thereafter at gradually increasing intervals.

After the infection has been controlled, urinalysis and culture at least twice a year are recommended. We have found that parents are reluctant to bring these children back for the necessary follow-up care or to give them medication when they are asymptomatic. This makes the art of medicine as important as its science for successful treatment.

The frequency of periodic urologic studies or treatments depends upon the presence of complicating conditions and the progress of the patient. Renal function is most conveniently followed by determination of the specific gravity of the urine, since a finding of 1.030 or more in these children is not uncommon and

confirms the presence of good renal function. If the specific gravity is reduced, a phenolsulphonphthalein excretion test is a convenient renal function test for office patients. Should Furadantin intolerance become a problem, the patient may accept a tablet crushed over syrup or mixed with carbonated beverage, peanut butter, or fruit preserves. In general the problem of tolerance is less with prophylactic doses, since intolerance usually depends on the amount administered. Intolerance seldom prevents prophylactic administration if the parents are convinced of the necessity of its administration.

Summary

In summary, our experiences and conclusions regarding the medical management of chronic urinary tract infection with Furadantin have been presented. They are based upon the 121 children we have followed for more than a year. A suggested plan of treatment has been outlined.

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Intussusception

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All cases in a metropolitan area of 700,000 people are reviewed. A constant high index of suspicion and early diagnosis are most important factors in keeping mortality low

MOST reports concerning intussusception are from centers where a concentration of infants and young children possibly weights the statistical data.[1, 2, 3, 4,5] After encountering several patients with intussusception who were older than usually expected, and finding a definite pathological etiology, I decided that possibly if all the cases in a community were accumulated, the statistics might vary from those published by children's medical centers.

Material

This is a review of the proved cases of childhood intussusception from all the hospitals in the metropolitan area of Louisville, from July 1, 1953 to July 1, 1959. The population of this area is 700,000. The records of 78 patients were obtained from record rooms, x-ray departments, surgical departments and pathology departments.

Etiology

The demonstrable cause was not found in 90% of the cases. Four of the patients had a Meckel's diverticulum, two had a duplication of the ileum, one a jejunal polyp and one a large lymphoma (Table I). This represents 10% of this series. None of these etiological agents was associated with necrotic bowel. Some form of bowel resection was performed for each. All did well in the hospital except one fatal Meckel's diverticulum which will be discussed later. Table II shows that 89.7% of the cases were of the ileo-colic type. The ileo-cecal type is included in this group because it seems impractical to separate it. There was one jejuno-jejunal, one jejuno-ileal, five ileo-ileal and one colo-colic intussusception. Three of the ileo-ileal intussusceptions could not be reduced. They were associated with potentially necrotic bowel and were resected. One of these patients died.

Table III shows the usual seasonal variation of the abnormality. Seventy percent of this series occurred during the late spring and hot summer months.

TABLE I

Etiology In 78 Patients

Meckel's Diverticulum	4
Duplication of Ileum	2
Jejunal Polyp	1
Lymphoma	1

One of the differences between this series and others is shown in Table IV. Only 51% of these patients were under two years of age and only 40% were under one year of age. Possibly many infants under two years of age are transferred to children's hospitals but those over two years of age are operated upon in other hospitals.

Clinical Manifestations

The signs and symptoms of intussusception are well known. An early index of suspicion must still be publicized, for the mortality rate rises with the duration of symptoms. Most often the presenting complaint is pain of a moderate cramping type. In this series it was the chief

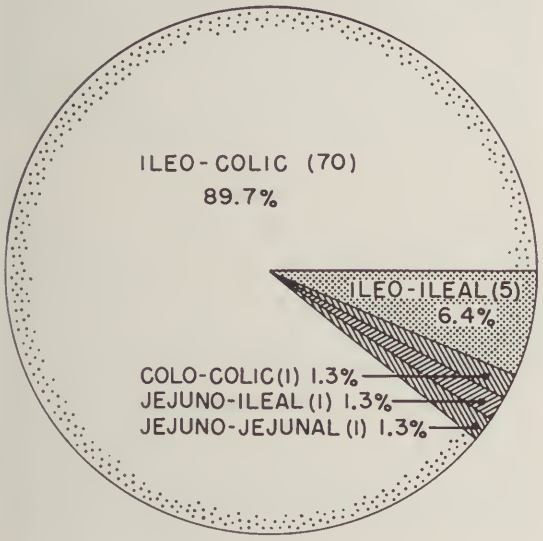
*From the Children's Hospital and Department of Surgery of the University of Louisville School of Medicine, Louisville, Kentucky.

complaint of 69% of the patients (Table V). Vomiting and/or diarrhea is frequently the chief complaint. Blood was passed by 41% of this series and again must be emphasized as an unreliable and late finding. All of the fatal cases passed blood except one ileo-ileal intussusception. The white cell count is of no diagnostic or prognostic value. In 58% it was below 12,000 on admission.

The most important element is time. There were no deaths when the diagnosis was made in less than 24 hours. The average duration of symptoms from onset of the chief complaint

TABLE II

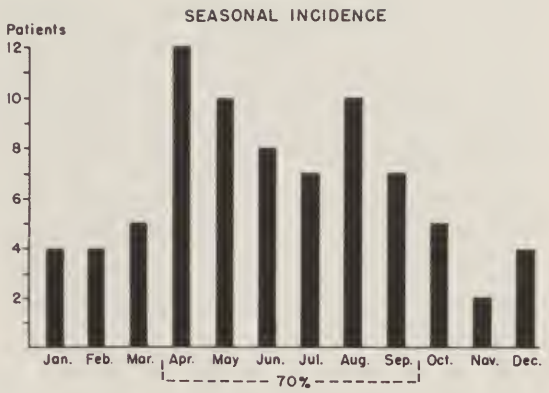
TYPES OF INTUSSUSCEPTION



to the time of admission to the hospital was 43 hours, which is longer than most authors report. However, this is extremely difficult to determine. Many patients do not have an explosive onset but have vague symptoms for days before admission to the hospital. Some are irritable, some have diarrhea and some vomit for several days before consulting a physician and it is impossible to state the duration of symptoms in hours.

A mass was palpated in 44% of this group. A more careful, patient and gentle palpation of the abdomen should double this low percentage. In many it can be palpated only on bi-manual examination. The rectal finger relaxes the abdomen and the mass can be felt with the opposite hand. Occasionally, the intussusception extends to within reach of the digital finger and the diagnosis is assured.

TABLE III



In the patients with typical signs and symptoms, x-rays were not needed. The literature has been filled with the pros and cons of reduction by enemas[1] or reduction by surgery[2] since Hirschsprung published his report of 107 personal experiences in 1905[6]. As in all illnesses, each patient is an individual and requires individual analysis. Some cases of intussusception are of such short duration and reduce so readily while being examined under the fluorosope that it is probably justified to assume that they are cured.

However[3], the basic objections to using this

TABLE IV

Pediatric Intussusception—
Metropolitan Louisville
7-1-53 to 7-1-59

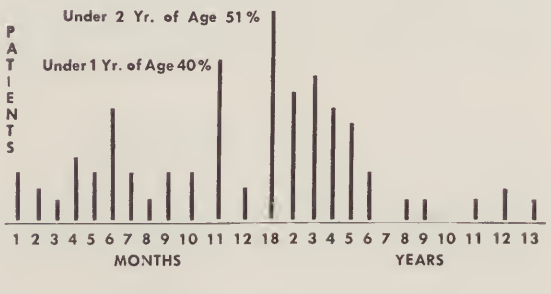


TABLE V

Clinical Manifestations

Chief Complaint - Pain	69%
Palpable Mass	44%
Blood in Stools	41%
WBC Below 12000	58%
Definite Etiology	10%
Hours Before Dx	43
Days in Hospital	6.3
Mortality	6.4%

method are: (1) Valuable time is wasted since the intussusception seldom occurs during the office hours of the roentgenologist. (2) There is danger of perforation of bowel. (3) Non-viable bowel can be reduced unknowningly, as occurred in one of this series. (4.) It is difficult to be sure reduction is complete. (5.) An enteric intussusception may not be discovered. (6.) The causative factor may be missed. (7.) Recurrences of intussusceptions are approximately twice as numerous following this method[1].

In the Louisville metropolitan area the roentgenologists usually do not attempt with vigor to reduce the intussusception by enema. In spite of this, Table VI shows that 11 patients (14%) had the intussusception reduced by radio-opaque enema and had no further treatment. Twenty-eight patients (36%) were operated on without x-rays. Fifty patients received enemas, of which 48 were diagnostic. There were ten exploratory laparotomies on patients who had the intussusception reduced by radio-opaque enema. It is impossible to determine from the records the individual surgeon's reason for this, other than assuming it was one of the seven listed above. The radio-opaque enema was diagnostic but did not reduce 29 intussusceptions.

Treatment

Table VII outlines the treatment carried out in this series. The 18 cases having bowel resections include all of those with a known etiology, and, therefore, were not resected necessarily for non-viable bowel. The only patient in this series not proved by x-ray, surgery or autopsy was a boy with a classical history and physical findings. It was believed that the intussusception was reduced by the surgeon during the physical examination and he was very confident of his diagnosis.

TABLE VI

X-Ray Data	Patients	Per Cent
Diagnosis by BA Enema	48	61.5
Ba Enema not Diagnostic	2	2.6
Ba Enema not Done	28	35.9
Reduced in X-Ray-no Surg	11	14.1
Reduced in X-Ray-Surg	10	12.8
Not Reduced by Ba Enema	29	37.1

TABLE VII

Treatment Of 78 Patients

Reduced by BA Enema—No Surg	11
Reduced in Surg. Appendectomy	28
Reduced in Surg. No Appendectomy	6
Found Reduced. Appendectomy	13
Bowel Resection	18
No Surgery—Autopsy	1
History & Physical Only	1

Death

The five deaths in this series are analyzed in Table VIII. Cases A and B require no explanation. Both were terminal on admission and one died while receiving blood and electrolytes preoperatively and the other received blood and electrolytes but died a few hours after surgery. Case C was readmitted to the nursery at 8 days of age for diarrhea and vomiting. He improved many times but generally remained in a poor condition. Two days before surgery he began having bloody stools and vomiting again. A barium enema proved the intussusception. He was given blood and

TABLE VIII — DEATHS

Case	Age	Chief Complaint	Mass	Temp	Bled	WBC	Cond On Adm	Length Of Symp	Hosp Days	BA Enema	Surgery
A	2 Mo	Diarrhea	Yes	100	Yes	7700	Term.	3 Days	1	No	Bowel Resect
B	5 Mo	Vomiting	No	101.6	Yes	8100	Term.	3 Days	¾	No	None—Autopsy
C	6 Wk	Diarrhea	No	99	Yes	10400	Poor	2 Days	38	Yes	Bowel Resect
D	6 Mo	Vomiting	No	101	Yes	8300	Good	2 Days	4	Yes	Bowel Resect
E	3 Yr	Pain	Yes	99	No	9050	Good	1 Day	5	No	Bowel Resect

electrolytes. Necrotic bowel was resected and the youngster died the same day.

Case D is more difficult to analyze and it may be presumptious to assume that he died of over-hydration. An ileo-colic intussusception was reduced in the operating room and a Meckel's diverticulum and appendix removed. The fluid order on the chart stated "100 cc. of fluids per pound next 24 hours," which he did receive daily until he died on the third post-operative day. He weighed 14 lbs. Most of the fluids were 5% glucose in water plus 375 cc. of normal saline daily. No autopsy was obtained.

One Error In Diagnosis

Case E was the only error in diagnosis. A pre-operative diagnosis was appendicitis and an appendectomy was done on the day of admission, but the youngster's symptoms were unchanged and the pathology report returned as a normal appendix. Two days later an exploratory laparotomy for intestinal obstruction revealed a necrotic ileo-ileal intussusception which was resected. He died the second post-operative day.

It is interesting that none of the fatal cases had a WBC over 11,000. All had bowel resected. Only one had pain as the chief complaint, which may have caused the delay in hospitalizing these youngsters. Again, it should be stressed that all had symptoms longer than 24 hours. Four of the five had rectal bleeding which again points out that it is a late and bad prognostic sign.

Discussion

If surgeons are to be encouraged to operate upon infants in hospitals especially equipped for this type of surgery, then it must be shown that the results are better in these surroundings. This is best illustrated by the difference in mortality rate of 6.4% in this metropolitan area as compared to about 2% from most children's hospitals statistics. The mortality rate at Louisville Children's Hospital for these years was 2.1%. The results are dreadfully poor in hospitals where only one or two cases are handled yearly.

There is no satisfactory explanation for 49% of these patients being over two years of age (which is contrary to all teaching) but it makes one think that intussusception is quite common up to six years of age.

There were 33 patients (42%) who probably could not have been benefited by attempting opaque enema reduction. Certainly the five deaths would remain unaltered. The eight patients with a known etiology would require surgery under any circumstances. There were 11 patients who had an ileo-colic type of intussusception with symptoms longer than 72 hours and who received a barium enema, but it did not reduce the intussusception. Most of these probably would not have been reduced with greater effort. There was one ileo-cecal intussusception not diagnosed with the barium enema. Three patients had an ileo-colic type and required resection of the terminal ileum for devitalized bowel. Two patients had an ileo-ileo-colic type and required resection of the ileum for devitalized bowel. One patient had a jejuno-ileal intussusception four days following a Swenson pull-through procedure for Hirschsprung's disease and did well. Two ileo-ileal intussusceptions would have been overlooked and surgery possibly delayed.

It is easy to imagine that another death or two might have resulted if too much reliance were placed on the results of barium enema. Surely there is the occasional patient with mild symptoms of short duration who can safely be reduced by enema and no further investigation is needed. However, the policy of operating and sleeping well that night results in a mortality rate which has not been lowered by any other method.

Summary

(1) All the cases of childhood intussusception from a Metropolitan area of 700,000 people are reviewed. (2) The age differences between cases reported from Children's Hospitals are discussed. (3) It is shown that the mortality rate for this disease is lower in those hospitals with separate facilities for pediatric problems. (4) Treatment by radio-opaque enema versus surgery is discussed.

Acknowledgements

The author wishes to express his apprecia-

tion to the authorities of the following hospitals from which this material was collected:

Children's Hospital, Louisville, Kentucky
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Pewee Valley Hospital, Pewee Valley, Kentucky
Red Cross Hospital, Louisville, Kentucky
St. Anthony Hospital, Louisville, Kentucky
St. Joseph Infirmary, Louisville, Kentucky
SS. Mary and Elizabeth Hospital, Louisville, Kentucky
Clark County Memorial Hospital, Jeffersonville, Indiana
Floyd County Memorial Hospital, New Albany, Indiana
St. Edward's Hospital, New Albany, Indiana

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Ulcerative Colitis In Childhood

In 53 cases of ulcerative colitis in children, diagnosis was established by characteristic findings on sigmoidoscopy; in another 9, clinical considerations left little doubt. The commonest age at onset was 8 years, but 7 cases began in the first year of life. Blood in the stools was frequently the initial symptom, early morning diarrhea was often marked, tenesmus occurred in 33 cases, and abdominal pain in 35. Onset of the disease was insidious in 45 cases and abrupt in 17. The series included 2 brothers, and a brother and sister; in 5 other families there was a history of ulcerative colitis in close relatives. One-fifth of the children were Jewish. Psychological disturbance in the family was apparent in less than half the cases. There was only one case with an acute, fulminating, and fatal course, but arthritis occurred in 17%. Most children were given high-protein low-residue diets. Steroids often produced a rise in hemoglobin levels when iron failed, but even with the use of steroids, iron therapy and transfusion remained valuable. Chalk and opium mixtures, hog's stomach, and desiccated ileum were used orally. Retention enemas were also tried. Steroid therapy was employed in 21 cases with no improvement in 3, probably because of too small a dosage. Of 12 surgically treated patients, 9 had undergone ileo-rectal or ileo-colic anastomosis in single or multiple stages. Five of 6 had no serious trouble at the time this paper was written, the 6th had a fecal fistula, and 3 patients were greatly improved. Two patients had died of carcinoma in their 3rd decade. Of 5 other deaths, 4 might have been averted by surgery. Long-term follow-up showed that 60% of the patients were well.

—J. W. Platt, B. E. Schlesinger and R. F. Benson, Quarterly Journal of Medicine, London: Page 257 (April) 1960

CASE DISCUSSIONS
From The
University of Louisville Hospitals

Louisville General Hospital

A Case Of Secondary Gout†

Charles C. Smith, M.D.* and Warren Kemper, M.D.**

THE coexistence of gout and blood dyscrasias is well known. Secondary gout has been reported to be associated with the following hematologic disorders: polycythemia vera, chronic leukemias, myeloid metaplasia, multiple myeloma, sickle cell disease, pernicious anemia, thalassemia, hemolytic anemias, Waldenström's hyperproteinemia and lymphoblastomas. It is estimated that approximately 10 per cent of cases of clinical gout represent secondary gout associated with a blood dyscrasia.

We have recently seen two young Negro females with sickle cell anemia who presented with fairly classical articular symptoms of acute gouty arthritis and hyperuricemia. The following case report describes one of these patients.

Case Report

L. G., #174906, a 34-year-old colored female who had been followed since 1948 for sickle cell anemia at the Louisville General Hospital, was seen in the emergency ward on March 22, 1959, complaining of pain in the right great toe. Late on the evening of March 21 the patient noted spontaneous onset of swelling, redness and increased warmth of the right great toe with exquisite tenderness causing her to visit the emergency ward at 1:24 a.m. on March 22. Symptomatic therapy was administered in the form of codeine.

She was seen in hematology clinic on April 3, 1959, at which time none of the cardinal signs of inflammation were noted in her right great toe. Serum uric acid was 8.1 mg/100 ml (normal value—below 5.0 mg/100 ml) and the NPN was 24 mg/100 ml. X-rays of the right ankle and foot were normal.

On May 19, 1960, she again came to the emergency ward in the evening (8:48 p.m.) with complaints of redness, swelling, increased warmth and tenderness of the right great toe. Physical examination at this time revealed an oral temperature of 100.5° F. The right first metatarsophalangeal joint was swollen, tender, hot and red with desquamation of the skin overlying the joint. The patient left before a consultant could examine her and received no treatment. X-ray of the right foot was normal.

On July 8, 1960, she was seen in hematology clinic, at which time she was asymptomatic. However, the patient was given colchicine tablets, 0.6 mgm, with instructions to take one every 2 hours in case of return of pain in the great toe. When seen on August 26, 1960, the patient stated that she had again developed tenderness of the right great toe in the interim. Immediate institution of colchicine therapy as previously outlined to her had resulted in complete relief of symptoms after 2 doses.

The patient was again readmitted for transfusion therapy from August 30 to September 9, 1960. Serum uric acids at this time were 9.6, 12.8, 9.6, and 8.8 mg/100 ml. A BUN was 35 mg/100 ml. The patient was discharged on probenecid, 0.5 Gm, twice daily, and colchicine, 0.6 mgm, daily. Nine days after institution of probenecid the patient again had an attack of pain, redness, and swelling in the right great toe. She did not take increased doses

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**Chief Resident in Medicine.*
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of colchicine at this time as previously instructed. However, the attack subsided within one or two days.

Review of past history revealed that the patient had single attacks of pain in the great toe in both 1957 and 1958 but did not seek medical advice. There was no history suggestive of renal colic. Sickle cell anemia was first diagnosed in 1938. The patient has been admitted previously to this hospital 16 times for transfusion therapy from 1948 to 1960.

There was no family history suggestive of gout or sickle cell anemia.

General physical examination revealed a pale, colored female with prominent malar eminences. The nail beds and mucous membranes were pale. The heart was enlarged to the left and a blowing, mid-systolic murmur was heard over the entire precordium. The spleen and the liver were not palpable. No tophi were visible or palpable. There were numerous scars on the pretibial skin.

Review of the laboratory work done over the past 12 years showed that the hemoglobin concentration had ranged from 4.0 to 8.0 Gm/100 ml. There was a persistent leukocytosis. Reticulocyte counts ranged from 6-11 per cent and serum bilirubins ranged from 1-2 mg/100 ml. A chest X-ray showed generalized cardiomegaly. Hemoglobin electrophoresis revealed S hemoglobin.

Discussion

This patient is presumed to have gout, based on the typical history and physical findings, elevated serum uric acid, and response to colchicine. An acute attack soon after institution of probenecid lends weight to this diagnosis.[1] Since familial gout occurs in males in a ratio of 20 to 1 and is relatively rare in Negroes, we feel that this is an unlikely diagnosis and represents secondary gout occurring in conjunction with a hemolytic anemia.

The clinical, biochemical and pathological findings in familial and secondary gout may be indistinguishable. The difference lies in the mechanism. Familial gout is considered to be the result of an increased formation of uric acid due to an inborn error of metabolism, while secondary gout represents a disturbance in uric acid metabolism due to an increased formation or destruction of blood cells.

Talbott[2] suggests that the increase in formation of cells with the concurrent increase in the metabolism of nucleoproteins is the precipitating factor resulting in acute gouty attacks. He bases this partially on the observation that venesections may precipitate gouty attacks in polycythemia vera. It is postulated that the stress placed on the hemopoietic system by venesection and the resulting increase in nucleoprotein metabolism is responsible for the hyperuricemia. Also supporting this theory is the fact that secondary gout tends to be associated with hyperplasia of the marrow.

The association of sickle cell anemia and gout is probably rare. To our knowledge there have been only three previous cases reported.[2, 3] This association may be difficult to recognize since articular symptoms play a prominent role in the clinical picture of sickle cell anemia. In sickle cell anemia the increase in nucleoprotein metabolism occurring with the hyperplasia of the bone marrow may explain the acute gouty attacks.

The management of acute gouty arthritis secondary to sickle cell anemia is basically the same as that of familial gout. Colchicine seems to be the drug of choice for acute attacks. As in primary gout, the use of an uricosuric agent such as probenecid along with maintenance dosages of colchicine is indicated in the intercritical periods.

Summary

A case report is presented of secondary gout associated with sickle cell anemia. The incidence, mechanism and management of this form of gout are discussed.

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SPECIAL ARTICLES

The Facts Of Life In The Future Of American Medicine*

JOHN B. RECKLESS, M.B., CH.B.†

I BELIEVE that a comparison can be made between the practice of medicine here and the practice of medicine in Great Britain as it was before the National Health Service. There are, of course, differences, but basically it was a system of private enterprise giving, or trying to give, comprehensive medical care.



Dr. Reckless

So this then is to be my theme: To take a look at some of the changes arising as a consequence of the British National Health Service; a look at the attitudes of the patients; an attempt to review the beneficial changes, for there have been many, many good things which have arisen as a result of the British National Health Service. But there are other things that were not expected, that are not so popular and which have led to difficulties for the British physician.

Let me first begin by telling you just what the National Health Service covers. I am sure every one of you knows it covers a complete physician care, at the family doctor and hospital level. Hospitalization covers both in-patient care and out-patient diagnostic procedures. It also covers a lot of other things — dental care, extractions and provisions for dentures. It covers sight testing and provision for spectacles. It covers appliances, even wigs and toupees, if considered necessary for therapeutic reasons.

There are even more things to come. The service provides complete ambulance service. Any sick person requiring an ambulance telephones and is taken to the hospital. It covers the home nursing care of patients who are convalescing or who don't require hospitalization. It will even provide domestic help if a mother is ill and unable to take care of her family. It provides maternity and death benefits. This is literally a cradle to the grave, or, dare I say it, provides care from the womb to the tomb.

I would like now to consider the economics of the service. I am sure many people have heard that many doctors in England are dissatisfied with the pay scale. We are also, I think, very dissatisfied with the per capita fee system. By this system, a doctor is paid approximately $3.00 per patient for 24-hour coverage for 365 days of the year. A doctor is permitted to have a maximum of 3,500 patients. Technically, he may have private practice as well, but, as you will see, private practice has diminished to approximately five per cent. There are very few doctors today who live solely by private practice. Thus, if a doctor has a maximum number of patients, which few have, he is hard put to care for 3,500 patients.

A quick translation into American terms, which is made by economists in England and America, shows that if a man carries 3,500 patients, then he will have a buying power equivalent to $8,110 before deduction of taxes and practice costs. That doesn't sound perhaps too much but this puts such a doctor in an income group which is in the top 1.4% of income levels in the country.

The average number of patients is 2,500, and gives a standard of living equivalent to $6,000. If a physician earns this sum of money, then he is in the top 2.5% of the national income group.

The patient pays the equivalent of $1.32 per week, with the employer paying $1.08 and $.90 for men and women respectively. This averages out 3.6% of the average annual wage, or $140 per year from direct contributions and indirect taxation. All these figures were calculated very carefully and were published in 1958. Over here, on a similar scale, the average earner would pay $186 per year.

The National Health Service takes approximately

**Address delivered at the President's Luncheon September 21, 1960, during the Annual Meeting of the Kentucky State Medical Association in Louisville, Kentucky.*

†Duke University Medical Center, Durham, N. C.

10% of the budget. This is a fact which the public did not realize and is a point which I think is important for people over here to understand. This is that a government can levy charges for a service not only directly by taking a contribution from a person's income, but also by direct and indirect taxation.

Now your taxation per head is calculated at 24%. Our direct taxation is 40%, and is a matter of great embarrassment for the politicians. Of course, the service blossomed and is so expensive that few countries could afford to imitate this; however, I have a feeling that many are trying.

How did this service come to be? Is this the product of a communist or near-communist government? Not at all! This service had its inception in 1911, which is when the government started its first compulsory health insurance bill. This was called a National Insurance Act. This provided family doctor care for any worker earning less than $775 a year. All workers and employers had to belong to this system. They had a very good reason when it was first formed, for it was to protect the wage earner. You can see that he received the appropriate care at the necessary time and this would be for the ultimate benefit of the worker's family. But what it didn't do was provide for the wife and dependents. It also did not provide hospital coverage or specialist consultation. But it did offer free medicine.

Profession Skeptical

When this system came in, the profession was a little skeptical about it, but over the course of the years it was accepted and the medical profession itself recommended in 1930 and 1938 that the scheme be broadened to include the family, and to include consultant, opthalmic, dental and maternity care.

Then came the war, and of course, all plans went on the shelf. In 1942, a gentleman named Beveridge produced a system of comprehensive coverage. We had a coalition government at that time with Winston Churchill as prime minister. It was Winston Churchill's government which said that as soon as the war ended, "We'll give this broad coverage."

The profession then became a little anxious and negotiations began to take place. In 1944 one of the members of the government proposed a full-time salaried hospital srevice with the doctor working for the local city authority. This, of course, was rejected outright. But both parties, both the conservative and labor parties, when they went to the polls in 1945 had as their platform a comprehensive medical scheme. Both were committed to introducing such a service.

Well, as you know, it was the Labor Party, the left wing, that was elected and they announced quite arbitrarily that whatever the profession felt, they were going to introduce their scheme on July 5, 1948. This was announced in 1946.

Well, there was tremendous hustle and bustle in the profession; everyone running in different directions and taking different viewpoints. A referendum was taken and only 17% of the profession were willing to join such a service. We said to the government, "How can you work such a scheme if you have no doctors? You have only 17%."

The man in charge, Aneurin Bevan, said, "I don't care. I'm going ahead."

This is how they started that old government maneuver, "divide and conquer," which I am sure is applicable here as well as in other countries. He said, "If a doctor joins now, we will buy his practice and the good will. Secondly, we will give him seniority in the service. And thirdly, we will give full pension rights after ten years in the service."

Sufficient Practitioners By 1948

The older men who were looking toward retirement felt this as an inducement to join the service. There was leadership; plenty of voices were raised, but there was no unanimous voice. A second referendum was taken and 49% of the profession signified they would take part in this scheme. The government said, "We have 49%, so we are going ahead." This they did, and by 1948 they had sufficient practitioners to initiate the service.

At this point, I would like to switch to the second part of my presentation. You have heard it said that I am a psychiatrist. When people ask what I am, I tell them I am a physician. If they press me, I say I deal with mental diseases. This reminds me of a story of the school teacher who was asking her pupils what their fathers did. She came to one little boy and said, "What does your father do?"

He said, "My daddy plays the piano in a burlesque house."

She didn't think this was a very good moral background for the boy, so she arranged for a visit to his home. She found he had an address in a very fashionable suburb of the city. It was a beautiful house. When she rang the bell, a maid answered. She said, "I would like to see Johnny's father." The maid showed her into a library, where a distinguished looking man met her. She said, "Good gracious me! You're not a bit like what I had expected. Your son, Johnny, said you played piano in a burlesque house."

He said, "Well, actually, I'm a psychiatrist, but I haven't the heart to tell the boy."

Likes and Dislikes

Now I want you to imagine that I am not alone on this platform today. On my left I have Dr. X, who is a general practitioner in the days preceding the National Health Service. On my right I have Dr. Y, who is a general practitioner in the National Health Service. I am going to ask them to tell you their likes and dislikes.

Let me first diverge, however, and say that 85% or thereabouts of our profession is in general practice. The rest are specialists. If a patient wishes to have a specialist consultation he usually went through the recommendation of his general practitioner.

Now let's call on Dr. X. He is a well set up gentleman. He has a good suit, a nice car, not the equivalent of a Cadillac, Chrysler, or Lincoln, but it is a good car and it is paid for. He tells you that one of the things he likes about the practice of medicine before the National Health Service is, first, that he can practice where he pleases. I am sure it is the same

here, that a man has a choice of a resort area or a country practice where perhaps there are more difficulties in getting started and when you are established there is less income but life is very pleasant. Or one can go into an industrial community where there are always more patients than doctors—where one can recover the cost of one's education quickly and have a fairly high standard of living even though you don't have time to enjoy what you make.

Now this is very comforting because a man knows that whatever he chooses he can change his location. As a doctor becomes older, he may have a cardiac condition and want to take life easier. Dr. X will tell us he knows he can sell his practice and buy a practice at a seaside resort or in the country. This is very comforting for him.

The other thing he likes is the clinical freedom. He is responsible to his colleagues and his conscience and his patients—nobody else. Since all the specialists are dependent upon him for referrals, he is well considered by the specialists. His opinion is solicited. He is encouraged to put a patient in the hospital and take care of him—with the help of the appropriate specialist. This was a very, very nice arrangement. An interesting patient could be admitted to the hospital and the general practitioner could prescribe appropriate treatment. He could take holidays when he liked and, of course, like all doctors, he enjoys a very comfortable status in the community. He could be a civic leader and be very respected. People would solicit his opinion on many things outside medicine.

What He Doesn't Like

The things that Dr. X doesn't like are the cost of drugs and the cost of hospitalization for a patient who didn't have much money. He didn't like, I think, the fact that he would like to make more visits with certain patients but financial circumstances precluded this. The other difficulty was that our specialists were dependent upon private practice and they had to be located around the large cities and teaching hospitals.

There are problems in neuro-surgery or thoracic surgery, especially from trauma, when it might not be possible to get an appropriate specialist, except by transporting the patient to a bigger center.

How about Dr. Y? He doesn't look quite as happy. He looks harassed. Let's ask him to tell us what he likes and what he doesn't like.

The things he likes are that now there is a comprehensive system providing medical care for all people regardless of social and economic status. This is very comforting. He likes the fact he can visit as he wishes. And he likes the annuity scheme whereby 6% of his income and the equivalent of 8% from the government are put together to provide an annuity when he retires.

One of the things he dislikes is the fact that he no longer owns his own practice. He dislikes the fact that he has difficulty in practicing where he chooses. We have more doctors applying for vacancies than vacancies are available. A doctor, whenever he reads of a vacancy may put his name forward, but there may be as many as 30 doctors competing for that one vacancy. If he is in an industrial center and would like to switch to a country practice it can be difficult. Transfers can be made but with nowhere near the same ease as before the inception of the service.

And another thing is that when the doctor is older, the National Health Service Authority, consisting of predominantly non-medical people, and responsible for appointing that doctor, may look at the problem differently and say, "We want a young doctor, one who will be able to practice for a few years to come." This also makes it very difficult for the older man to transfer.

There is, of course, the question of private practice. The government paid lip service to the fact that private practice could co-exist with the National Health Service. But there is one restriction that has caused a lot of heartburn in the profession. Although everybody belongs to the service, if a person comes to you as a private patient, any drugs that you prescribe for the patient he has to buy himself. You know very well the cost of antibiotics, and in the case of a serious illness this can amount to a tremendous sum of money. Therefore, this has been a very great deterrent against people consulting a physician privately.

Patients Go 'On the Service'

High taxation has meant that middle income groups and even upper income groups have had difficulty meeting their taxation and therefore they come to the doctor and say, especially when they wish to educate the children: "Doctor, I have been a patient of yours for a good many years. We have always been good friends, but I am afraid I am going to have to go 'on the service.' " You understand the position, of course, and so another patient is lost to private practice.

You heard me say that the average doctor is in the top 2.5% of income bracket and yet you will recall that the physicians in Great Britain agreed to strike. A tremendous percentage, I think 70%, agreed to withdraw from the service.

Now we as a profession tend to be conservative and a strike is very distasteful. Yet so strongly did physicians feel about it. Why? Because when the government came into power they gave assurance with a rise in the cost of living there would be an increase in the remuneration. But the cost of the service was so great that the government said, "We can't afford to pay you more." Our claims have been put off and put off by sucessive governments, who say, "A decision taken by a previous government cannot be binding upon us today."

When we agreed to withdraw from the service, the government met it in a very skillful manner. They said, "We will give an immediate 10% raise to all interns and residents." Since they earn the equivalent of $90 a month, this wasn't much. And they said, "We will submit the claims of the profession as a whole to a Royal Commission." A Royal Commission takes up to three years to sift the evidence and present its findings.

Immediately those in the profession who found the strike distasteful said, "Well, the government is doing something. Let's co-operate and wait."

So another three years have gone by and here we are on the eleventh year. There have been some ad-

justments but the adjustments have nowhere near equalled the rise in the cost of living.

Another thing is that such a scheme destroys incentive. No matter how few patients you see, your income is the same. As far as the patient is concerned, no matter how often or little they attend, the charges which they pay are the same. So this has led to a number of abuses.

In 1958 the profession took stock of the service after ten years. They found that a number of good things had happened.

There was a dispersion of specialist services and an upgrading of hospitals. All hospitals were given an adequate number of consultants. The men were very well qualified and every town and every city had its complement of specialists. This means from a doctor's point of view he can refer a patient to any hospital and know that patient will get very competent, efficient care.

Another thing is that it is comprehensive medical service.

Some very unusual things have happened, however, and I am sure the same sort of thing could happen over here.

Government Embarrassed

In the first three years of the service, in a country of 48 million people, there were 609 million prescriptions and drugs issued. Seven million sets of dentures were issued. Seven hundred thousand appliances were issued. Of course, the cost just skyrocketed. The government was embarrassed and didn't know what to do. So they had to impose restrictions. They said you must pay a shilling on a prescription. A shilling is approximately 14 cents.

You would pay up to a maximum of $2.80 if you went to a dentist for a tooth extraction.

You would pay $4.20 towards the cost of spectacles.

You would pay $12.00 towards the cost of dentures.

And, of course, the actual deductions from the payroll also increased. So the consumer, the patient, John Q. Public, as he is referred to in another presentation, was paying through direct deduction from his payroll and also by heavy direct and indirect taxation.

To give you an example of the indirect taxation, we had a sales tax as high as 66% on automobiles, and a tax of 50% plus on luxury items, such as all electrical appliances, ice boxes television sets, furs, jewelry, cameras—a tremendous sales tax. So, you see, the patient is paying a tremendous sum of money for the service, and unfortunately, I am sure this is your dilemma, too. The public doesn't view things in a long-term way.

In 1956 the cost of bottles for giving away the free medicines was $2,800,000. And the money spent on research in mental health was approximately $200,000.

I am sure you heard that 500,000 people are waiting for elective surgery, and they are still waiting, tonsillectomies and things of that kind. For that, one has to wait.

Another thing, no new hospitals were built. We had suffered, of course, because a number of hospitals had been destroyed in the blitz during the war. There was an urgent need. The population had expanded. But no new major hospitals were built.

Now how has this affected the status of the individual physician? I am sure it is a point of great interest to you all. Doctors, of course, have now had a greater number of patients to take care of, or at least a greater number of visits by patients. This means in order to see everyone a doctor has to treat, I am afraid, the disease rather than the patient.

Now the treatment and diagnosis have been thorough and efficient. But if you have 20 to 30 or even 40 patients in the office you don't have time to talk about little Willie's scholarship to the university of grand-dad's corns, or what is going to happen when the patient's teen age daughter marries Joe Bloak down the street. You have to treat the disease. You do not have time to give the patient the sort of contact that you had before the service. I think now, especially with young people, this is a problem. I spent time in different types of general practice in three locations. I think that the young people now tend to regard the doctor as a man whose services have been paid for, and therefore if a patient feels he needs to be seen, whether for a headache of for aspirin, or he needs to take time from work and wants a sick note, he will come to the doctor. He feels the doctor is being paid and has the right to see the doctor. If the doctor is busy, that's too bad. He says, "Doctor, I come once a year. You think it is not important. Nevertheless, I am not a doctor and I want to consult you."

A Government Servant

The physician is regarded more now as a government servant. I think this inevitably is going to have an effect upon the caliber of men entering the profession. I am very proud to belong to the British medical profession. I think you are all aware that our standards are as high as anywhere in the world and the individual caliber of the men is very high. But one thing that has come out is that fewer and fewer physicians are persuading their sons to enter the profession. I think this is very revealing.

Of course, the status of the physician's wife has inevitably been altered because of the fixed income, and with private practice diminished, a doctor can't afford to have all the help he would like. Therefore, more and more wives are assisting their husband-physicians.

Another thing that has happened which I am sure is very serious is that the control of the profession has now moved out of the profession. Before, a man was responsible to the General Medical Council. This was composed of his colleagues nationally elected who would deal with any matters of discipline or ethics.

Now he is responsible to a National Health Tribunal and National Health Executive Council. The G.M.C. is still there but the things that affect a doctor's livelihood and independence and right to practice are now under direct government control. A doctor can be reprimanded or suspended from the service for a deficiency which is not medical. If a doctor consistently misplaces his National Health records he will be reprimanded. If it continues, he can be suspended from the National Health Service.

And you can imagine what it will entail.

All prescriptions are checked at routine intervals and if it is found that one doctor is consistently prescribing more than his colleagues in that area, he will be called to account to the appropriate National Health Service body for this so-called over-prescribing. If they find he has been over-prescribing, this money is deducted from his remuneration.

The other thing that happens is there are certain items that fall into the no-man's-land of drugs or food. I am thinking of patients who have liver damage. Certain preparations are challenged as a food and the practitioner is told: "This is not to be given under National Health Service. Therefore, we are deducting the cost from your remuneration." He may appeal but the appeal may have to go all the way through the National Health Service channels.

Now will it happen in this country? Your guess is as good as mine and I believe your feeling of the tenor of the situation in America is greater than mine.

U. S. Audience Reaction

I want to tell you of one thing that astonished me recently. At a meeting in the United States, I heard speak Mr. Hugh Gaitskell, the leader of the British Labor Party, who would have been the Prime Minister had his party been successful in the last election. He addressed an open meeting of middle class people. During the question and answer period, inevitably the question came up, "What is your opinion of the socialized medicine you have in Great Britain?" And his answer was very fluent and elicited what to me was an astonishing reaction from the audience.

He replied, "We don't call it socialized medicine. That's what it is called over here. We call it the British National Health Service and if you want my opinion, I consider it the greatest social reform in the history of the British House." He received sustained applause from that audience. It may seem naive, but I was astonished and very surprised. The significance of this I will leave to you.

We have the Forand Bill and we have other areas that you are all aware of, where the Federal Government is making inroads but, as I say, I feel this can be understood better by you and your colleagues.

In conclusion, where did we go wrong? First, we had no organization to meet the government on the same ruthless footing. They used the technique, and I am sure you are aware there is a probability of that here, which is, "Divide and conquer." They divided the profession. One deal for the specialists and another deal for the practitioner. All the time chopping the profession into groups and sub-groups. Although everybody was protesting, there was no one unanimous voice.

Secondly, and I wonder if it is applicable here, is the lack of public support. We tried to rally the people. Although individually they had a tremendous liking and respect for the physician as a person, I think in every country there is something of envy for the profession as a whole. I notice here when I go into a shop to buy something, I get this reaction: "Doctor, this is our standard line. You don't want this. You want the deluxe model." Which is three times as much. This is a very unfortunate attitude for the public to have.

We had special conditions that I think were peculiar to Great Britain. We had just emerged from the war. Many physicians had returned from overseas. They were starting a family and they wanted to get out and practice and they didn't take the threat seriously.

I think if we could go back we would have adopted a policy of trying to effect a compromise favorable to us. One which would enable us to give the patient the type of care we think he needs and deserves and the type of care that can be made possible under our control.

We were warned. We had a long period of warning. We saw it coming and we didn't react to it.

Will it change? No. Politically it is dynamite. A politician concerned with getting back into Parliament or Congress or that Senate is not going to vote for something that the public is against and that is why I don't think our own system will change.

What I would like to finish with is this thought: The scheme has a lot of very good points; it has a lot of things which make it unpopular with the physician, with the patient and the politician, each for a different reason. Somebody said on the B.B.C. film which I heard last Saturday, "Everbody points the finger and says, "What a wonderful scheme it is,' but no country yet has felt wealthy enough to introduce the scheme as we did in one slam-bang." But a lot of countries are introducing it piecemeal and in the Commonwealth and Canada they have schemes of various sorts. Also in Australia, New Zealand, Germany, Italy and the Scandinavian countries. It is coming, not with one move, but piecemeal, and I think it seems inevitable.

Challenge Must Be Met

Therefore, we have to meet the challenge and give something to the patient which is good for him and good for us.

I think you have in prepayment medical plans an effective challenge to government sponsored health insurance. Over the last few days, I am also aware that there are difficulties with these, both from the patient's and the physician's viewpoint. I urge you to resolve these difficulties.

Why do I say that prepayment medical insurance is an answer to government intervention in the medical field? Simply this, over the last few years in the United Kingdom, over four million patients who belong to the service have voluntarily taken out private prepayment medical insurance. This means they are paying yet again to recover something which they feel is worth having.

The British National Health Service has succeeded because of the integrity of the British physicians who made it work despite their own feelings. The private insurance is expanding rapidly because the British physicians also want it to work and we are making every effort to see that it does.

I feel, therefore, that prepaid medical insurance especially the type offered by Blue Shield, will be one answer to the situation which you have here in America.

The future rests in your hands.

EDITORIALS

March Of Dimes — 1961

THAT the State of Kentucky has been the principal beneficiary in the allocation of March of Dimes funds raised in the state over the past 23 years was disclosed in a financial summary prepared by The National Foundation.

More than 73 cents of every dollar from Kentucky's March of Dimes has been put to use in aiding the state's disease victims and in research and education projects conducted in the state. Of the remaining 27 per cent accruing to the national headquarters, a considerable amount also has come back to Kentucky in shipments of polio vaccine and gamma globulin and in other nationwide services conducted by The National Foundation.

The summary covers the period since the first March of Dimes was held in January, 1938, and compares the net total of funds raised in the state with amounts made available to Kentucky through September 30, 1960.

In this period, Kentucky's 120 chapters of the March of Dimes organization raised a net total of $7,787,940.20 at an average fund-raising cost of 7 per cent. Of this amount, $5,555,191.18 has been available to the county chapters in carrying out their extensive patient aid programs, including advances of $2,261,-863.61 from the national office to meet local emergency situations.

In addition, eight grants totaling $163,612.68 have been made in support of research and professional education projects at the University of Louisville.

Over and above the 73 per cent used by county chapters and by the university, The National Foundation has financed within the state projects such as the historic field trials which proved the effectiveness of the Salk vaccine, epidemiological studies and scholarship and fellowship grants to Kentucky residents. National headquarters' expenditures for the vaccine trials in Kentucky amounted to $63,290.23. In addition, the national office has sent into Kentucky $98,156.59 worth of Salk vaccine and 55,560 cc's of gamma globulin in support of its polio prevention programs.

Two years ago, the National Foundation for Infantile Paralysis changed its name to The National Foundation in expanding its areas of interest beyond polio to include birth defects and arthritis, using the scientific knowledge and experience gained in the fight against polio.

The New March of Dimes takes place throughout the month of January.

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The above report, just made available to us, is reproduced in our Journal for general information concerning the operation of the Polio Prevention Program in our State. It affords an occasion to call attention to the fact that this program has lagged very appreciably in the last two years and a large segment of our population remains unprotected. Instances of paralytic poliomyelitis continue to occur in greater frequency than they should. Some persons in middle life have been stricken.

In the initial period, because of the limitation of vaccine, the immunization of children and pregnant women was especially stressed. It is thought by the best authorities that, since the vaccine is now plentiful, immunization should be carried on without regard to age. It is very probable that many of the physicians who read this Journal have not themselves been immunized against polio, and it is much more likely that the wives and adult members of their families have escaped the immunizing program. This carelessness and lethargy are inexcusable.

At the interim meeting of the American

Medical Association in Washington during November and December of 1960, the Board of Trustees issued a report stating that, in view of the insufficiency of a supply of oral polio vaccine for 1961, the continued use of the Salk vaccine for the prevention of poliomyelitis should be strongly recommended. This report also took into account that many segments of population throughout the country remain unimmunized against this disease.

The above report also makes brief explanation of the change of name from The National Foundation for Infantile Paralysis to The National Foundation. While it continues to be concerned with the prevention and treatment of poliomyelitis, it also includes in its program research, efforts at prevention and treatment in virus diseases, arthritis, birth defects, and other central nervous system disorders. Funds made available through the 1961 March of Dimes crusade will therefore serve a wider field of usefulness than previously.

While we as physicians have slackened our interest and zeal in the campaign for vaccination against poliomyelitis, we also have been negligent in insistence that those of our clientele keep up their vaccination program against smallpox, diptheria, typhoid fever, and tetanus. Booster doses of these vaccines should be encouraged and, whenever possible, the patient should be advised when the next vaccination or booster injection is due. The same precaution may well be encouraged in the use of the newer polyvalent influenzal vaccines for the prevention of influenza and upper respiratory infection.

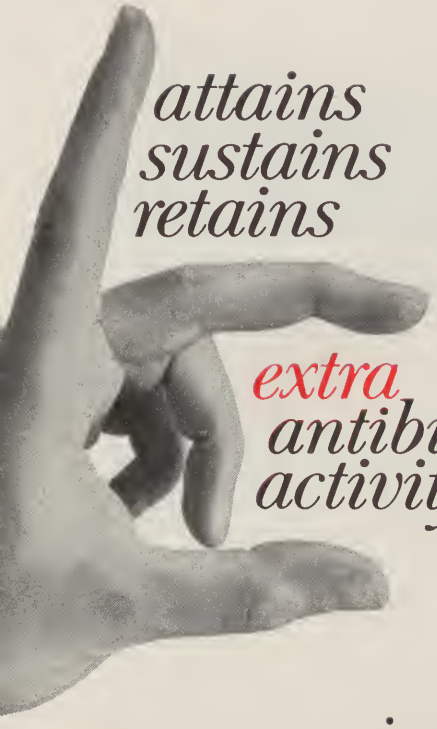
Sam A. Overstreet, M.D.

Plan to Attend

11th Annual County Society Officers Conference

Phoenix Hotel, Lexington

Thursday, April 6, 1961



attains
sustains
retains

extra
antibiotic
activity

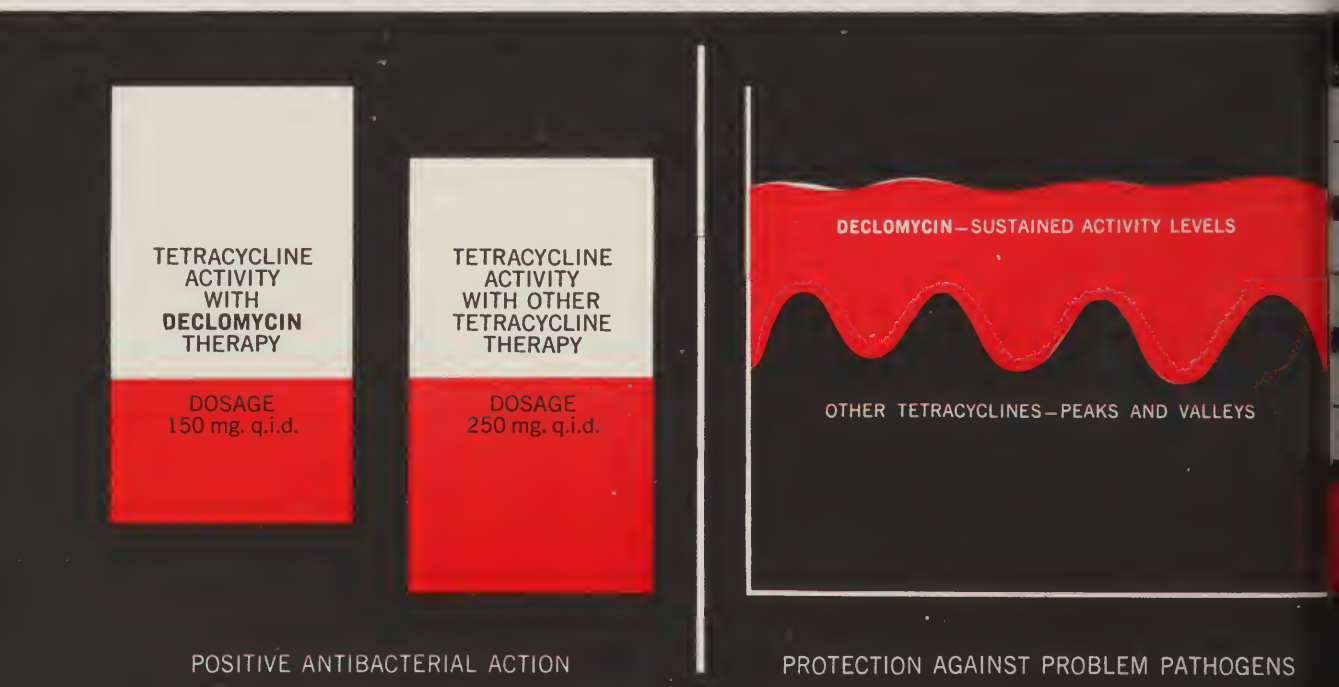
DEC

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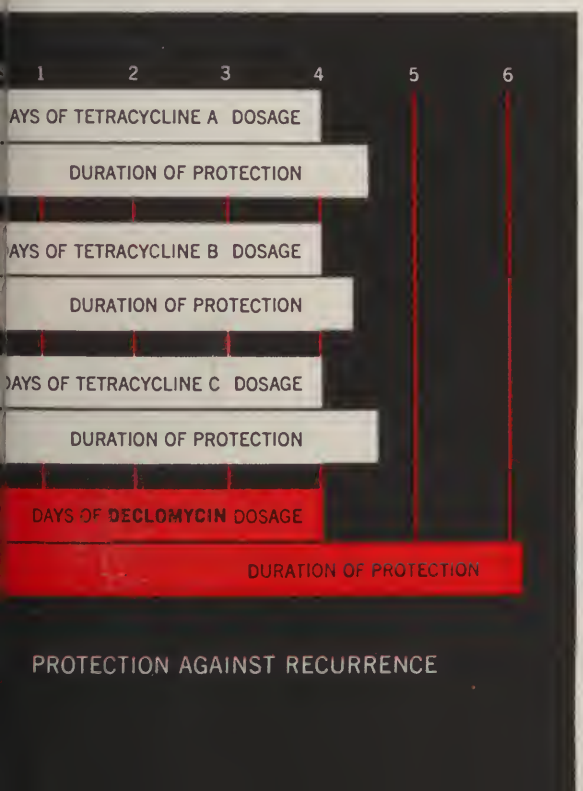


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LOMYCIN Demethylchlortetracycline retains activity levels up to 48 hours after the last dose is . At least a full, extra day of positive action may be confidently expected. The average, daily adult ge for the average infection—1 capsule q.i.d.—e same as with other tetracyclines...but **total** ge is lower and duration of action is longer.



CAPSULES, 150 mg., bottles of 16 and 100. **Dosage:** Average infections—1 capsule four times daily. Severe infections—Initial dose of 2 capsules, then 1 capsule every six hours.

PEDIATRIC DROPS, 60 mg./cc. in 10 cc. bottle with calibrated, plastic dropper. **Dosage:** 1 to 2 drops (3 to 6 mg.) per pound body weight per day—divided into 4 doses.

SYRUP, 75 mg./5 cc. teaspoonful (cherry-flavored), bottles of 2 and 16 fl. oz. **Dosage:** 3 to 6 mg. per pound body weight per day—divided into 4 doses.

PRECAUTIONS—As with other antibiotics, DECLOMYCIN may occasionally give rise to glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis or dermatitis. A photodynamic reaction to sunlight has been observed in a few patients on DECLOMYCIN. Although reversible by discontinuing therapy, patients should avoid exposure to intense sunlight. If adverse reaction or idiosyncrasy occurs, discontinue medication.

Overgrowth of nonsusceptible organisms is a possibility with DECLOMYCIN, as with other antibiotics. The patient should be kept under constant observation.

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ORGANIZATION SECTION

Top Speakers To Address County Society Officers Conference

Congressman John C. Watts, Sixth District, Kentucky, along with top leaders in the AMA, the National Blue Shield Commission and the American Farm Bureau Federation, will be featured at the 11th Annual County Society Officers Conference, which will be held Thursday, April 6, in the Phoenix Hotel in Lexington.



Dr. McKeown

The morning session will be devoted to critical problems within the profession and suggestions as to what may be done to solve them, KSMA President Richard G. Elliott, M.D., Lexington, explained in making the announcement. The luncheon session, at which Congressman Watts will speak, and the afternoon meeting will consider medicine's present position in the legislative arena.

"Medicine's Answer to Professional Disciplinary Problems" will be one of the feature presentations of the morning program, Doctor Elliott said. It will be given by Raymond M. McKeown, M.D., secretary and treasurer, a member of the Board of Trustees of the AMA, and chairman of the AMA's committee studying medical disciplinary problems. Doctor McKeown practices at Coos Bay, Ore.

In addition to Congressman Watts and Doctor McKeown, the conference will hear Norman Welsh, M.D., Boston, Mass., immediate past president of the National Blue Shield Commission and Speaker of the AMA House of Delegates; Roger Fleming, director of the Washington, D. C., office, and Leo Brown, AMA's director of the Division of Communications.

Doctor McKeown finished second in his class of 109 at the University of Toronto Faculty of Medicine, following earning an A. B. degree at the University of Oregon in 1924. In 1929 he accepted an internship at Yale University School of Medicine.

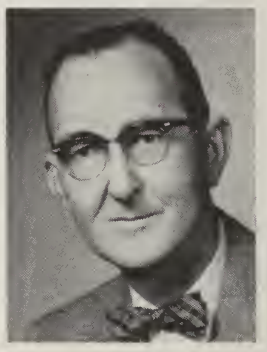
On returning to Oregon, he immediately became active in organized medicine and civic affairs. Widely known for his talents as an after-dinner speaker, he has served, among other positions, as president at the Oregon State Medical Society, mayor of his home town, and president of its Chamber of Commerce. He is also a member of the Sears Foundation Advisory Board and the AMA's Council on Medical Services.

Ky. M.D.'s Attend Snyder Dinner

Kentucky's AMA Delegates—W. Vinson Pierce, M.D., Covington; and Robert C. Long, M.D., Louisville—and KSMA President-elect Gaithel Simpson, M.D., Greenville, attended the House of Delegates dinner on November 28 honoring Maj. Gen. Howard McC. Snyder, MC, USA. Doctor Snyder, 79-year-old personal physician of President Eisenhower, was given a citation for "a lifetime of distinguished service to humanity."

Dr. Dickinson to Head Board of Ky. Physicians Mutual

John Dickinson, M.D., Glasgow, was elected president of the Board of Directors of Kentucky Physicians Mutual—the Blue Shield Plan for Kentucky—at a meeting of the board in Louisville on November 17. He succeeds J. Vernon Pace, M.D., Paducah, who served a two-year term in that office.



Dr. Dickinson

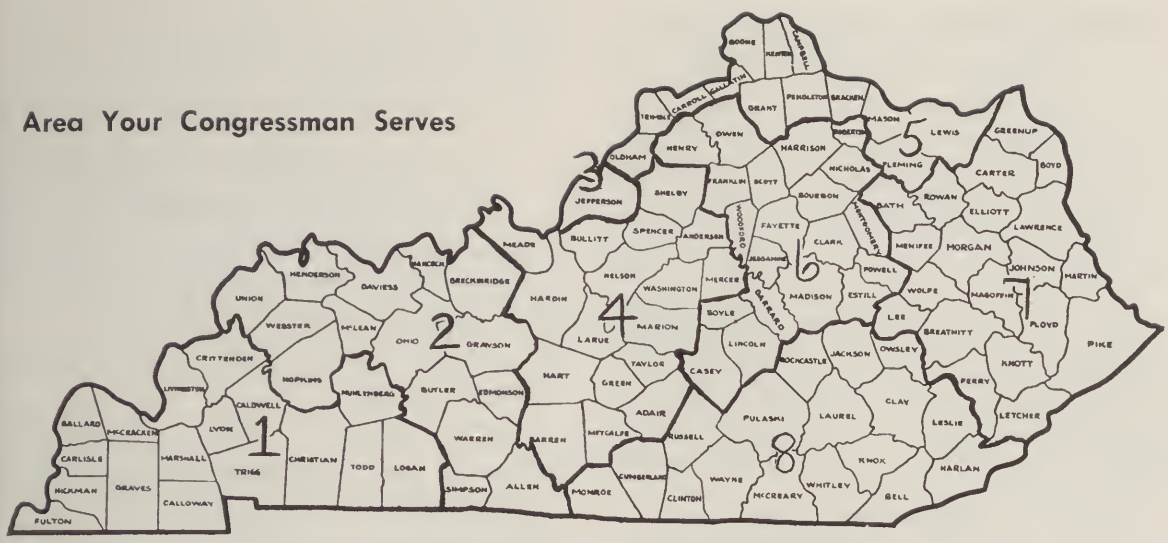
Doctor Dickinson, a 1933 graduate of the University of Louisville School of Medicine, served 45 months in the U. S. Army during World War II on surgical service of the 39th General Hospital in the Pacific. He is a Fellow of the American College of Surgeons, the Southeastern Surgical Congress and the Kentucky Surgical Society and is vice-president of the Kentucky Society.

Richard Rust, M.D., Newport, was elected vice-president of the Kentucky Physicians Mutual Board, succeeding William H. Cartmell, M.D., Maysville. Renamed secretary was J. P. Sanford, KSMA executive secretary. Branham Baughman, M.D., Frankfort, will continue as treasurer.

AAP Admits 5 Kentuckians

Five Kentucky physicians were admitted to membership in the American Academy of Pediatrics during the year 1960, according to E. H. Christopherson, M.D., Evanston, Ill., executive director of the Academy.

The new Kentucky members are Billy M. Adams, M.D.; J. W. Fowler, M.D.; Robert Royce Kidd, M.D., and Richard F. Greathouse, M.D., all of Louisville, and Noble T. Macfarlane, Jr., M.D., Lexington.



This map shows the boundaries of the various congressional districts

You Will Need This Information When You Get Ready To Contact Your Congressman and Senators In Washington

Legislative proposals, many of which will be of critical significance, will be presented in the first session of the 87th Congress which started the first of the month, according to George P. Archer, M.D., Prestonsburg, chairman of the KSMA Council on Legislative Activities.

Since you will want to contact your congressman and senators from time to time, in order to give them the benefit of your views on these all-important matters, *The Journal* is giving you complete contact information on our lawmakers in the table below.

Your Council on Legislative Activities urges you to remain in close contact with your lawmakers in Washington.

U. S. SENATORS

Name	Home Address	Capital Address	Telephone
John Sherman Cooper (R)	Somerset	Room 110, Senate Office Bldg. Washington, D. C.	Capitol 4-3121 Extension 2542
Thruston B. Morton (R)	Glenview	Room 259, Senate Office Bldg. Washington, D. C.	Capitol 4-3121 Extension 4343

U. S. REPRESENTATIVES

	Name	Home Address	Capital Address	Telephone
1	Frank A. Stubblefield (D)	Murray	Room 1228, House Office Bldg. Washington, D. C.	Capitol 4-3121 Extension 3115
2	William H. Natcher (D)	Bowling Green	Room 117, House Office Bldg. Washington, D. C.	Capitol 4-3121 Extension 3501
3	Frank W. Burke (D)	Louisville	Room 220, House Office Bldg. Washington, D. C.	Capitol 4-3121 Extension 5406
4	Frank L. Chelf (D)	Lebanon	Room 449, House Office Bldg. Washington, D. C.	Capitol 4-3121 Extension 3465
5	Brent Spence (D)	Fort Thomas	Room 1129, House Office Bldg. Washington, D. C.	Capitol 4-3121 Extension 2305
6	John C. Watts (D)	Nicholasville	Room 1534, House Office Bldg. Washington, D. C.	Capitol 4-3121 Extension 4706
7	Carl D. Perkins (D)	Hindman	Room 1409, House Office Bldg. Washington, D. C.	Capitol 4-3121 Extension 4935
8	Eugene E. Siler (R)	Williamsburg	Room 209, House Office Bldg. Washington, D. C.	Capitol 4-3121 Extension 4601

AMA Washington Office—1523 L Street, N. W., Washington, D. C. Sterling 3-8155

Manager—Roy Lester, M.D.; Legislative Representatives—Mr. Cecil Dickson and Mr. James Foristel

KAGP Northern Kentucky Seminar Set Jan. 19 In Cincinnati

"Gastroenterology" is the subject announced for the Northern Kentucky Seminar of the Kentucky Academy of General Practice, set for January 19 at the Sheraton Gibson Hotel, Cincinnati. Registration will open at 9 a.m. (EST) and the program will start at 10, according to James A. Schroer, M.D., Newport, chairman.

Essayists for the morning session and their subjects will be: Arthur M, Schoen, M.D., Louisville, "Differential Diagnosis of Abdominal Pain"; Robert L. Summer, M.D., Henderson, "G. P. and G. I. Complaints," and Charles H. Brown, M.D., Department of Gastroenterology, Cleveland Clinic, Cleveland, "Nervous Patient and His Gastro-Intestinal Tract."

The afternoon scientific program will be presented by William A. Altemeier, M.D., professor of surgery at the University of Cincinnati, speaking on "Complications of Diverticulitis of the Colon and Their Surgical Management"; Stuart A. Safdi, M.D., assistant professor of the Department of Gastroenterology, University of Cincinnati, "Infectious Hepatitis"; Jerome F. Wiot, M.D., assistant professor of roentgenology, University of Cincinnati, "Roentgen Examination of the Acute Abdomen," and Richard Segnitz, M.D., past professor of pediatric surgery at Marquette University, "Common Pediatric G. I. Conditions."

Herbert Salter, M.D., Cleveland, will be the luncheon speaker, discussing "Self Discipline."

Charles W. Justice, M.D., Ludlow, will act as moderator for the morning session. For the afternoon program the moderator will be Taylor W. Baker, M.D., president of the Southwestern Ohio Society of General Physicians.

Cost of Medical Care Studied By New AMA Commission

A Commission on the Cost of Medical Care, authorized by the AMA House in July, 1960, is now in operation under the direction of C. Joseph Stetler, of the AMA Law Division in Chicago. Commission chairman is Louis M. Orr, M.D., Orlando, Fla., and vice-chairman is David B. Allman, M.D., Atlantic City.

It will be the Commission's job to identify and assess the "casual factors determining the prices of and expenditures for the components of medical care" by: (1) reviewing and evaluating pertinent studies completed or in progress; (2) suggesting or initiating additional research studies on medical care costs and expenditures; (3) endeavoring, on a continuing basis, to improve the understanding of physicians and citizens of the factors determining medical care prices and expenditures; and (4) reporting its findings and making appropriate recommendations.

The Commission will be made up of three committees: one on diagnosis and therapy; one on financing mechanisms (headed by Donald H. Stubbs, M.D., Washington, D. C., a speaker at the 1959 County Officers Conference), and one on economics of medical care. It is estimated that it will take about three years for the Commission to complete its work.

FCC Assigns Radio Frequencies For Use By Physicians

Radio frequencies for use by physicians, hospitals and ambulances are now available under revised rules of the Federal Communications Commission, according to a notice in *The Citation,* prepared by the law department of the AMA. The new ruling became effective December 1.

The Commission has allocated eight new frequencies in the 152-162 Mc. band to the Special Emergency Radio Service for physicians, the Red Cross and similar users, excluding hospitals and ambulances. Five new frequencies in this band have been provided for the exclusive use of hospitals and ambulances.

Public health agencies do not come under the new ruling, but frequencies in the Local Government Service still will be available to them.

The American Medical Association has been active in obtaining the use of radio frequencies as an adjunct to the services rendered by its members and hospitals.

New Medical Deduction Needs Explaining to Patients

Your patients who are supporting parents will appreciate your calling their attention to a new tax form to be used when claiming medical deductions. A new act, known as Public Law 86-470, authorizes a full deduction for medical expenses incurred in behalf of the dependent parents of a taxpayer or of his spouse if the parents are 65 or older.

The new tax form—No. 2948—will be filed in addition to the regular tax returns, the Internal Revenue Service has announced. The usual April 15 deadline for filing has been postponed to April 17 because the 15th this year falls on Saturday.

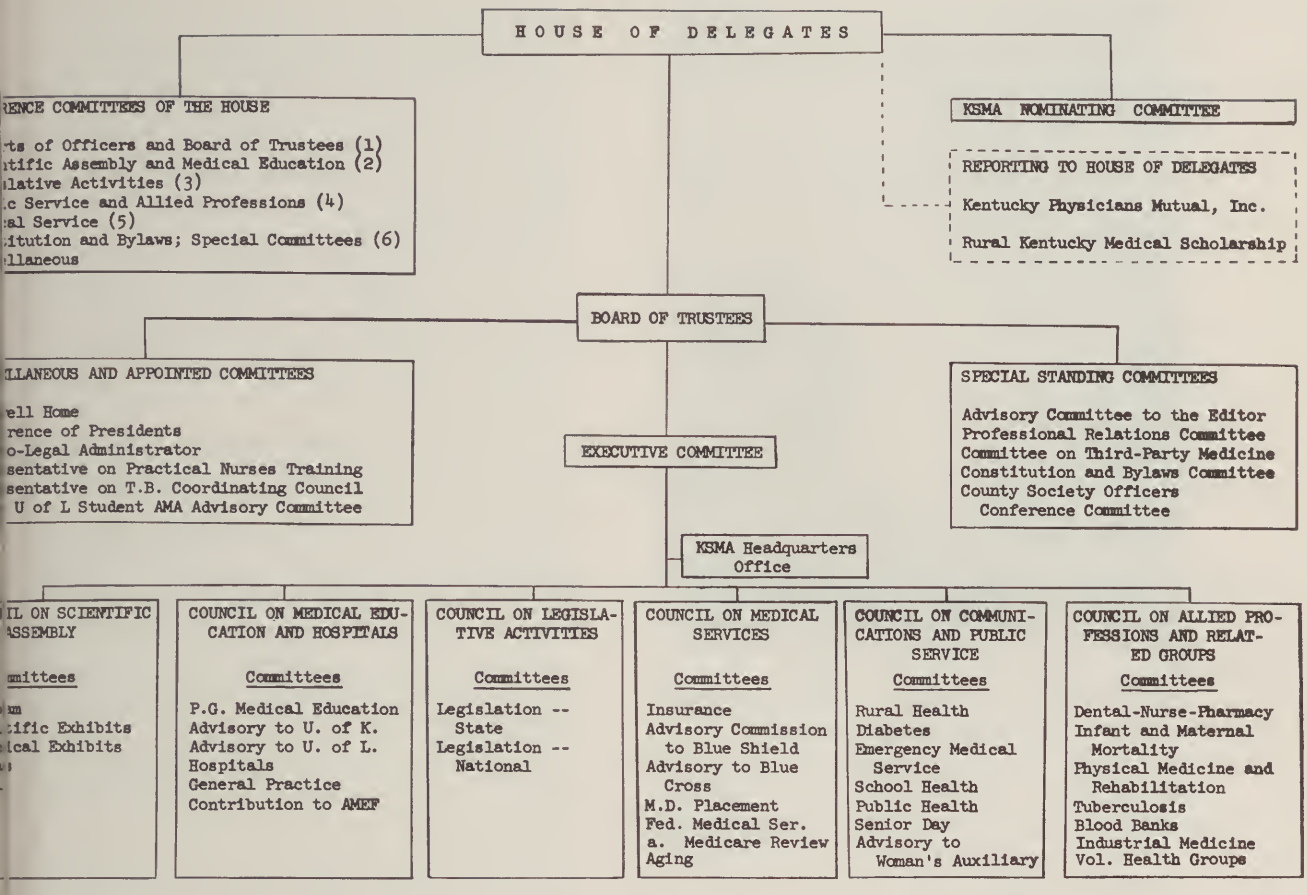
The KSMA House of Delegates has requested that physicians inform their patients about the new law.

U. L. Alumni Elect Dr. Giannini

J. Thomas Giannini, M.D., Louisville, chairman of the KSMA Committee on Scientific Exhibits, has been elected president of the University of Louisville Medical Alumni. He is a 1938 graduate of the U. of L. School of Medicine.

Other newly-elected officers are Walter S. Coe, M.D., vice-president, and Hoyt D. Gardner, M.D., secretary-treasurer. Doctor Coe is chairman of the KSMA Council on Medical Education and Hospitals, and Doctor Gardner is a member of the KSMA Building Committee.

Named to the executive committee were David Cox, M.D.; George McAuliffe, M.D., and George Sehlinger, M.D. All are Louisville physicians.



KSMA's New Organizational Setup Is Explained

Changes of vast significance in the KSMA committee structure that are designed to streamline the Association's organizational setup were voted by the KSMA House of Delegates at the 1960 Annual Meeting.

The new KSMA organizational chart, above, shows how the various agencies and committees have been restructured.

First, it should be remembered that the KSMA's interim governing body, which operates the Association between meetings of the House of Delegates and is responsible to the House for all of its actions, is no longer known as "the Council." The interim governing body is now known as "the Board of Trustees"—the change is in name *only;* all functions, duties and responsibilities remain the same.

Second, with the freeing of the name "Council," as described above, the word is now used in creating an organizational level between the governing body and the committee level. The *program work* of the Association has been allocated to six divisions called "Councils" as indicated on the chart—with committees in the area served by a given council grouped under it.

The Council is not a policy-making organization. (That is the function of the House and the Board of Trustees). The purpose of the Council is to stimulate its committees, assist and encourage them in their work. The Councils will accept referrals of problems from the House, Board or officers for study and recommendations. It may also initiate projects for study and recommendations on its own.

New Bylaws require the Councils to meet at least twice a year, once at beginning of the Associational year to get its work under way. Another meeting must be held at least six weeks before the Annual Meeting to make its report to the House of Delegates via the Board of Trustees. Councils may hold other meetings as indicated, Committees of a given Council report to it—not to the House.

These changes were the outgrowth of suggestions by KSMA President Richard R. Slucher, who in 1957 asked the House to authorize the KSMA Constitution and Bylaws Committee to make a thorough study of our committee structure with the view of streamlining and improving. The Bylaws Committee spent three years perfecting recommendations and taking them through the necessary procedures.

This explanation of the reorganization of the Association's activities and the chart must necessarily be brief. Any member desiring additional information should write to the KSMA Headquarters Office.

Advertising Charges Explained By Committee Chairman

As requested by the House of Delegates at its 1960 meeting, James E. Hix, M.D., Owensboro, chairman of the Advisory Committee to the Editor, has submitted the following explanation for *The Journal's* system of charging voluntary health agencies for advertising.

The Journal, a non-profit publication, must meet its printing costs out of its budget, and printing costs have increased greatly since *The Journal's* inception. Because of the great number of voluntary health agencies, it would be too expensive to supply free space for every one, and it would not, of course, be fair to be discriminatory in choice of agencies receiving free space.

Therefore, in order to operate within its budget, and at the same time cooperate with these voluntary health groups, the committee decided that the cost of printing these ads would be on a 50-50 basis—with the KSMA paying half the cost and the group the other half.

KHA Offers Nurses' Scholarships To Winning Essayists

The Kentucky Hospital Association is offering four complete scholarships to Kentucky schools of nursing for seniors who submit to KHA the best essay on "My Contribution as a Nurse."

Sponsored annually by the council on public relations of the Kentucky Hospital Association, the contest is held to stimulate interest and to encourage students to enter the nursing profession. The scholarships will be awarded during the annual meeting of KHA in Lexington, March 21-23.

Scholarships are offered by Good Samaritan and St. Joseph Hospitals, Lexington; King's Daughters Hospital, Ashland; and by Kentucky Baptist Hospital, Nazareth College, Norton Memorial Infirmary and SS. Mary and Elizabeth Hospital, all in Louisville. Only one scholarship is awarded and financed by each school and essay winners must pass pre-entrance exams.

4,124 Admissions to State Mental Hospitals In Year Reported

Admissions to state mental hospitals totaled 4,124 in the fiscal year ending June 30, 1960—an increase of 1.4 per cent over the previous year, according to the eighth annual report of the Kentucky Department of Mental Health. The report was submitted by Harold L. McPheeters, M.D., Mental Health Commissioner, to Governor Bert Combs on December 12.

Figures also showed a 1.2 per cent increase in readmissions, a decrease in the number of direct discharges, but a 23 per cent increase in the number of leave placements. Ninety per cent of those discharged were in the hospital less than a year. Kentuckians spent $3.58 a day on each patient in the mental hospitals—an increase of 6 cents.

Among the year's accomplishments, the report pointed out that more freedom was given to patients, that some improvements were made to the four state mental hospitals, and that the 1960 General Assembly appropriated $3,000,000 for a major building program for Lakeland's Central State Hospital and passed legislation to "facilitate court-ordered admission and release procedures to treat mentally sick persons merely as sick persons."

The Department's constant awareness of the "need to assure that persons with emotional and mental problems are accorded the rights and dignity that belong to all humans living in the 20th Century" was cited by Doctor McPheeters as the keynote of his report to the Governor.

Louisville Hospital Survey Made

More than 130,000 persons were hospitalized in Louisville in 1959; more than 65,000 operations were performed, more than 30,000 pints of blood were used in patient care, and laboratory examinations totaled 1,829,101. These are some of the statistics revealed by a survey conducted for the Hospital Conference of Metropolitan Louisville during the past year.

Other facts include: More than 7½ million meals were served in the 20 hospitals in metropolitan Louisville during the year; more than 18,000 births were recorded; more than 1,000 registered nurses are employed full time, and another 281 serve on a part-time basis; more than 6,000 persons are employed full time; the payrolls exceed $20 million.

Florida M.D. Named GP of Year

James T. Cook, M.D., Marianna, Fla., was chosen AMA's General Practitioner of the Year at the opening meeting of the House of Delegates on November 28. Doctor Cook, the 14th recipient of the award, at 44 is the second youngest physician to be so honored.

Presentation of a gold medal and citation outlining his accomplishments was made by Julian Price, M.D., chairman of the AMA Board of Trustees. In making the presentation Doctor Price said, "Doctor Jim Cook is typical of the modern physician who combines his talents to bring the best of scientific medicine to the American people, yet has unlimited energies to devote to the service of his community." He has practiced in Marianna, a community of 8,500 persons, for 15 years.

Plan for Blood Typing Set Up

A "walking bloodbank" program for Campbellsville and Taylor County has been planned by the Campbellsville Lions Club with the full cooperation of the Taylor County Medical Society and Rosary Hospital.

Henry F. Chambers, M.D., has been appointed chairman of the joint committee to coordinate this drive. A walking blood bank is a record of the blood group and RH type of every individual who is a member of the blood bank. Every individual would be issued a card indicating blood type. It is hoped that everyone in the County will be blood typed under the program.

Varied Program of AMA Meeting Attracts Nearly 4,000 M.D.'s

A symposium on the present status of polio immunization, six hour-long closed circuit color television programs showing surgical procedures, 29 films on various aspects of medicine, numerous lectures, panels, and more than 200 scientific and technical exhibits were featured at the 14th Clinical Meeting of the AMA in Washington, November 28-December 1. Nearly 4,000 physicians attended.

Of particular interest to Kentuckians was a half-hour television show entitled "A School for Doctors" telling the story of the new University of Kentucky College of Medicine. The program was presented by Merck, Sharp, and Dohme in cooperation with the AMA as part of the "Ask Your Doctor" series. Host was John Cameron Swayze.

Surgeon General Leroy E. Burney was one of the participants in a discussion on polio immunization and the Sabin live poliovirus recently termed "suitable for use." One of President Eisenhower's physicians, Brig. Gen. Thomas W. Mattingly, took part in a symposium on coronary artery disease.

A surgical operation in which a synthetic joint is installed to replace one severely damaged by arthritis and a modified approach to surgery for duodenal ulcer were some of the subjects shown on color television under the auspices of Smith, Kline, and French.

Policy-making body of the AMA, the House of Delegates held sessions during the meeting. Representing Kentucky at these sessions were: delegates, W. Vinson Pierce, M.D., Covington, and Robert C. Long, M.D., Louisville; and alternate delegates, J. Vernon Pace, M.D., Paducah, and George Archer, M.D., Prestonsburg. (see the report on the House of Delegates meeting on page 62.)

25 Kentucky Physicians Attend AMA Clinical Sessions

Twenty-five Kentucky physicians attended the 14th Clinical Meeting of the American Medical Association in Washington, D. C., Nov. 28 - December 1.

Among those attending were Kentucky's delegates to the AMA, W. Vinson Pierce, Covington; and Robert C. Long, Louisville; the alternate delegates, J. Vernon Pace, Paducah, and George Archer, Prestonsburg; and president-elect Gaithel Simpson, Greenville.

Other Kentucky physicians listed as in attendance by the *AMA Daily Bulletin* were:

November 29—Norman Adair, Covington; M. R. Cronen, Louisville; W. H. Diessner, Middlesboro; James A. Freeman, Dawson Springs; Lyman S. Hall, Campbellsville; J. C. Hill, Louisville; Walter R. Johnson, Paducah; Owen B. Murphy, M.D., Lexington; Gabe A. Payne, Hopkinsville; Robert E. Pennington, London; C. E. Rankin, Lexington; S. E. Reynolds, Morehead; Otto H. Salsbery, Covington; Joseph Schikel, Burkesville; E. C. Seeley, London; Frank K. Sewell, Mt. Sterling; George Y. Shpilberg, West Point; Vincent Stabile, Louisville; and William R. Willard, Lexington.

November 30—Carroll L. Witten, Louisville.



Many KSMA members attending the AMA Clinical meeting in Washington, D. C., were interested in the scientific and industrial exhibits. Otto H. Salsbery, M.D., Covington, was a member of the committee which presented a "Special Exhibit on Fractures." Pictured is Owen B. Murphy, M.D., Lexington, pointing out a sports exhibit showing some medical aspects of sports to Marjorie F. Hughes, M.D., Arlington, Va.

Medical Care for Aged Discussed at Washington Conference

More than 500 representatives of state medical associations and the insurance industry attended a meeting to discuss medical care programs for the aged in Washington, D. C., on November 27.

The Conference on Federal-State Medical Care Program for the Aged, sponsored by the AMA's Council on Medical Service, emphasized the fact that "the new Medical Assistance for the Aged (the Mills-Kerr bill) offers far more potential medical care for our senior citizens than all Forand-type bills submitted in the 86th Congress."

Representing Kentucky at the sessions were: Gaithel Simpson, M.D., Greenville, KSMA president-elect; W. Vinson Pierce, M.D., Covington, and Robert C. Long, M.D., Louisville, AMA delegates; Walter R. Johnson, M.D., Paducah; and J. P. Sanford, KSMA executive secretary.

Harold Simms, M.D., was recently sworn in as a member of the Springfield City Council following the resignation of Council member Garland Pinkston. Doctor Simms will head the sanitation department.

Report Of Actions of the American Medical Association's House of Delegates At the 14th Clinical Meeting In Washington, D. C., Nov. 28 - Dec. 1, 1960

Kentucky was represented at the House of Delegates meetings during the 14th Clinical Meeting of the AMA by: W. Vinson Pierce, M.D., Covington, and Robert C. Long, M.D., Louisville, delegates; J. Vernon Pace, M.D., Paducah, and George P. Archer, M.D., Prestonsburg, alternate delegates; and Gaithel Simpson, M.D., Greenville, KSMA president-elect, representing President Richard G. Elliott, M.D., Lexington.

Doctor Long served as a member of the Reference Committee on Miscellaneous Business. William R. Willard, M.D., Lexington, dean of the U. of K. College of Medicine, and Michael R. Cronen, M.D., Louisville, caucused with the Kentucky delegation and covered the reference committees.

Doctor Long, KSMA junior delegate to the AMA, customarily reports on the interim session of the House of Delegates and Doctor Pierce, the senior delegate, reports on the annual meeting. Doctor Long's report follows:

A scholarship and loan program of medical students, the status of foreign medical graduates, an AMA membership dues increase, the expansion of voluntary health insurance, health care for the aged and new developments in polio vaccine were among the major subjects acted upon at the American Medical Association's 14th Clinical Meeting held in Washington, D.C., November 28-December 1.

Speaking at the Monday opening session, Dr. E. Vincent Askey of Los Angeles, AMA president, called upon the delegates to support not only existing AMA programs but also expansion of new programs necessary to meet the challenges of society. Dr. Askey assured the new administration in Washington of cooperation whenever and wherever possible but emphasized that the AMA will not change its policies merely for the sake of conformity.

Scholarship and Loan Program

The House of Delegates approved a scholarship and loan program proposed by the Special Study Committee of the Council on Medical Education and Hospitals, and also urged that there shall be local participation in the program at the state and county level. In commenting on the two-part program, the House approved the following statement by the reference committee:

"This proposed program will provide concrete evidence of the American Medical Association's sincere desire to attract increasing numbers of well qualified young people to enlarge the ranks of our profession. Your reference committee recognizes that the program is wisely designated to allow for its enlargement through the support of individual physicians and other groups. Your reference committee was impressed with the enthusiastic support of this proposal indicated during the course of the discussion. There was indicated a desire that in the final formulation of the administrative details of this program, provision be made for widespread participation by individual physicians as well as county and state medical societies. The program will clearly assist in securing highly talented individuals whose ability and leadership in all areas of medicine will be fostered and at the same time will bring needed financial assistance on a broad basis to medical students under a system in keeping with this Association's belief in individual responsibility."

Foreign Medical School Graduates

Meeting the problem of foreign medical graduates, the House of Delegates adopted a report which included the following statement:

"In order that those foreign physicians who have not yet been certified by the Educational Council for Foreign Medical Graduates might be given further opportunity to enhance their medical education, hospitals would be encouraged to develop special educational programs. Such programs must be of educational worth to the foreign graduate and must divorce him from any responsibility for patient care. Foreign physicians may participate in these programs until June 30, 1961, with approval of the Department of State so that their exchange visa will not be withdrawn before that time. This will also allow the non-certified foreign physician the opportunity to take the April, 1961, Educational Council for Foreign Medical Graduates examinations."

AMA Dues Increase

The House approved a Board of Trustees report which announced that a dues increase would be recommended at the annual meeting in June 1961. The report indicated that the amount would be not less than $10 and not more than $25 to be effective January 1, 1962. The Reference Committee asked the Board to consider an increase in the annual dues of $20, to be implemented over a period of two years: $10 on January 1, 1962, and $10 additional on January 1, 1963.

The House suggested that these funds be used to inaugurate or expand a number of programs including:

1. Financial assistance to medical students.
2. Continuing education for practicing physicians.
3. Health advice to the lay public.
4. Medical research.
5. The expansion by the Communications Division of its program of faithfully portraying the image of the American Medical Association.

It is important, the House emphasized, that the Board of Trustees report recommending a dues increase be transmitted in essence to the grass roots level.

Actions of AMA House of Delegates

In place of a Board of Trustees report and three resolutions, the House adopted the following substitute resolutions:

"WHEREAS it has been widely recognized that voluntary health insurance is the primary alternative to a compulsory governmental program; and

"WHEREAS the public has shown its confidence in this voluntary system; and

"WHEREAS current social, political and economic developments compel a new and revitalized effort to make voluntary health insurance successful; and

"WHEREAS the American Medical Association has consistently pledged itself to make available the highest type of medical care; therefore be it

"Resolved, That the House of Delegates direct the Board of Trustees and the Council on Medical Service to assume immediately the leadership in consolidating the efforts of the American Medical Association with those of the National Association of Blue Shield Plans, the American Hospital Association and the Blue Cross Association into maximum development of the voluntary, non-profit prepayment concept to provide health care for the American people; and be it further

"Resolved, That similar leadership be undertaken to coordinate the efforts of private insurance carriers through conferences with their national organizations; and be it further

"Resolved, That, where feasible, efforts be made to cooperate with representatives of other types of medical care plans, other professional groups, and representatives of industry, labor and the public at large."

Health Care for the Aged

The House reaffirmed the Association's support of the Kerr-Mills Bill, which was passed last summer, and its opposition to any legislation involving the use of the OASDI mechanism for medical aid to the aged. The delegates also urged all state and local medical societies to cooperate with the appropriate state officials and provide leadership in implementing the provisions of the Kerr-Mills Bill.

In connection with health care for the aged, the House suggested further experimentation in home-care programs, homemaker services and visiting nurse services. The delegates also recommended an increased emphasis at all levels of medical education on the new challenges being presented to physicians in the health care of older persons.

Polio Vaccine

The House agreed with a Board of Trustees report which said:

"In view of the fact that oral polio vaccine will not be generally available in sufficient quantity in 1961 for any large scale immunizing effort, the Board of Trustees of the AMA strongly recommends that the medical profession encourage the widest possible use of the Salk vaccine for the prevention of poliomyelitis. The Salk vaccine has been proved to be effective and since there are still many segments of the population not immunized against poliomyelitis every effort should be made to encourage the general public to take advantage of the Salk vaccine without delay."

The Board report was amended to suggest that a proper committee be established by the AMA to study the problems involved in administration of the new oral polio vaccine and to establish guides for physicians to follow when they are approached by various groups and asked for their support in administering oral polio vaccine.

Miscellaneous Actions

In considering a wide variety of resolutions and annual and supplementary reports, the House also:

Approved continuing study and periodic re-evaluation of the trend toward locating *physician's offices* in or adjacent to hospitals;

Directed the Committee on Medical Care for Industrial Workers to carry out its duties as previously instructed, following a spirited debate on the floor of the House. The House voted to amend the reference committee report and authorize the Committee on Medical Care for Industrial Workers to prepare guides for physician relationship with medical care plans in conformity with the clear policy already laid down by the House of Delegates at its December 1959 meeting. In the debate Kentucky supported the amendment to the reference committee report, along with Colorado, Texas, California, Indiana and New York;

Approved a set of guides relating to drug expenditures for *welfare recipients;*

Asked the Board of Trustees to study the question of blood replacement responsibility and also the matter of establishing health insurance fee schedules for *surgical assistants;*

Urged the Board to make every effort to reduce the number of physicians who are non-dues-paying members and approved a three-year study report on the relationships of *physicians not-in-private-practice* to organized medicine;

Requested the Board to present a completed *retirement* and *disability* insurance program for AMA members at the June, 1961, meeting, and

Agreed that the *General Practitioner of the Year* Award should be continued as at present.

Sports Subject of Conference

Presiding at a discussion of "On-Field Case of Football Player" at the second national conference on the Medical Aspects of Sports in Washington on November 27 was Owen B. Murphy, M.D., Lexington, a member of the AMA committee on athletic injuries.

Others from Kentucky attending the meeting were Carroll L. Witten, M.D., Louisville, and Bill Rudd, of the KSMA Headquarters Office staff. Purpose of the one-day conference, sponsored by the American Medical Association's Committee on the Medical Aspects of Sports, is to provide a forum for discussion of problems relating to the health of the athletes.

PG Course On ECG Interpretation Set Jan. 11—March 15

A 10-week postgraduate course on Electrocardiography Interpretation is scheduled to open Wednesday night, January 11, at Louisville General Hospital, under sponsorship of the KSMA Postgraduate Medical Education Office and the University of Louisville School of Medicine. The sessions will be held from 7 to 9 p.m. each Wednesday through March 15.

Essayist for the first five programs will be Herbert L. Clay, M.D., associate professor of medicine at the U. of L. School of Medicine. His introductory topic on January 11 will be "Introduction and Theory of Electrocardiography." On January 18 and 25 and February 1 and 8, he will speak on "Ventricular Electrocardiography—Simple Vector Analysis."

Subjects and speakers for the remainder of the course have been announced as follows:

February 15—"Effects of Digitalis, Quinidine and Electrolytes;" F. Albert Olash, M.D., instructor in medicine, U. of L. School of Medicine.

February 22 and March 1—"Abnormality In Impulse Initiation and Conduction;" Ralph M. Denham, M.D., instructor in medicine, U. of L. School of Medicine.

March 8—"Ventricular Electrocardiography—Simple Vector Analysis;" Herbert L. Clay, M.D.

March 15—"Review;" Doctor Clay, Doctor Denham and Doctor Olash.

The course has been submitted to the Kentucky Academy of General Practice for Category I Credit.

PG Office Sets Up Course On Hematology For March

A two-day postgraduate course on Hematology is scheduled for March 8-9 at the University of Kentucky Medical Center under the sponsorship of the KSMA's Postgraduate Medical Office, the U. of L. School of Medicine and the U. of K. Medical Center.

Twelve well qualified physicians, including eight from Kentucky, will be featured on the program which will open with registration at 8:30 a.m. on Wednesday, March 8, followed by welcoming remarks by W. R. Willard, M.D., dean of the U. of K. College of Medicine, at 9:45 a.m.

Following is the complete program:

Wednesday, March 8

10:00 a.m. **Introduction to Panel Discussion on "Anemia"**
Charles A. Doan, M.D., Columbus, Ohio

10:20 a.m. **Panel—"Refactory Anemias: Diagnostic and Therapeutic Consideration"**
Marion Beard, M.D., Louisville, moderator
Charles A. Doan, M.D., Columbus, Ohio
Douglas Ruff, M.D., Lexington
Thomas D. Stevenson, M.D., Louisville

11:45 a.m. **Discussion**

12:00 noon **Lunch**

1:30 p.m. **"Radio-Isotopes, Chromium, Iron and P32"**
Madison Cawein, M.D., Lexington

2:00 p.m. **Discussion**

2:10 p.m. **"Radiation"**
E. P. Cronkite, M.D., Bethesda, Md.

2:40 p.m. **Discussion**

2:50 p.m. **"Schillings Tests"**
Marion Beard, M.D., Louisville

3:20 p.m. **Discussion followed by adjournment**

Thursday, March 9

10:00 a.m. **Introduction to Panel Discussion on "Leukemia"**
James S. Hewlett, M.D.

10:20 a.m. **Panel—"Leukemia"**
Douglas Ruff, M.D., moderator
James S. Hewlett, M.D.
Marion Beard, M.D.
John Githens, M.D., Lexington

11:45 a.m. **Discussion**

12:00 noon **Lunch**

1:30 p.m. **"Platelets"**
Madison Cawein, M.D.

1:50 p.m. **Discussion**

2:00 p.m. **"Plasma Factors"**
Ellis A. Fuller, M.D., Louisville

2:20 p.m. **Discussion**

2:30 p.m. **Clinicopathological Conference**
Marion Beard, M.D., Case Presentation
James S. Hewlett, M.D., Discussion
Edward Fadell, M.D., Louisville, Pathology

Symposium on Heart Disease Set For Louisville, March 22-23

"The Life and Hard Times of a Cardiologist" is the subject of the talk which Irving H. Page, M.D., Cleveland, Ohio, former president of the American Heart Association, will make at the dinner during the eighth annual Symposium on Cardiovascular Diseases in Louisville on March 22-23.

Twelve nationally known speakers will headline the scientific program which is sponsored by the Heart Association of Louisville and Jefferson County and the University of Louisville School of Medicine.

Registration for the two-day session at the Brown Hotel is free. Jack Chumley, M.D., scientific editor of *The Journal* of KSMA, is symposium chairman. The full program will appear in the February issue of the *Journal*.

Dr. Chipps Heads Pathologists

H. Davis Chipps, M.D., Lexington, was installed as 1961 president of the Kentucky Society of Pathologists and M. David Orrahood, M.D., Owensboro, was named president-elect at a meeting in Louisville December 10. Elected secretary-treasurer was George Tanner, M.D., Fort Thomas.

Doctor Chipps, who had been serving as secretary-treasurer, succeeds John D. Allen, M.D., Louisville, as head of the society.

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SMOOTH-MUSCLE SPASM...

Prompt, Profound

Protection...at both

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Professional reliance on the therapeutic proficiency of Pro-Banthīne in functional gastrointestinal disorders has made it the most widely prescribed anticholinergic.

The consistent relief of emotional tensions afforded by Dartal makes this well-tolerated tranquilizer a rational choice to support the antispasmodic action of Pro-Banthīne in emotionally influenced smooth-muscle spasm.

These two reliable agents combined as Pro-Banthīne with Dartal consistently control both disturbed mood and disordered motility when emotional disturbances project themselves through the vagus to provoke such gastrointestinal dysfunctions as gastritis, pylorospasm, peptic ulcer, spastic colon or biliary dyskinesia.

USUAL ADULT DOSAGE:
One tablet three times a day.

SUPPLIED as aqua-colored, compression-coated tablets containing 15 mg. of Pro-Banthīne (brand of propantheline bromide) and 5 mg. of Dartal (brand of thiopropazate dihydrochloride).



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Research in the Service of Medicine

Postgraduate Medical Offerings Announced Through April

Postgraduate medical opportunities in Kentucky and adjoining states for the next three-month period are announced by the KSMA Postgraduate Medical Education Office.

Special attention is called to two postgraduate courses planned by this office. The first is a 10-week intermittent course on ECG Interpretation, to be held at Louisville General Hospital on Wednesdey nights from 7 to 9 o'clock, January 11 through March 15. The second is a two-day course on Hematology on March 8 and 9, at the new University of Kentucky Medical Center.

Detailed information on the listings may be obtained from the Postgraduate Medical Education Office, 104 West Chestnut Street, Louisville 2. The telephone number is JUniper 7-7135.

The complete listing follows:

January

11 through March 15 Postgraduate course, "ECG Interpretation," 10-week intermittent course, Louisville General Hospital, Wednesday nights, 7-9, Fifth Floor Classroom, Louisville.

19 Northern Kentucky Seminar, sponsored by the KAGP.

19-20 Postgraduate course, "Obstetrics & Gynecology"; University of Nebraska College of Medicine, Omaha.

23-27 Postgraduate course, "Pediatrics, Obstetrics and Gynecology"; University of Michigan Medical Center, Ann Arbor.

25-27 Postgraduate course, "Clinical Hematology"; University of Tennessee College of Medicine, Memphis.

28-30 Postgraduate course, "Man and Civilization: Control of the Mind"; University of California, San Francisco; $25 fee.

February

6 Starting (tentative) one-week clinical postgraduate course in Ob-Gyn, Louisville General Hospital; by appointment only; limitation, two physicians per week. Course to be given throughout the year 1961.

6-7 Postgraduate course, "Electrocardiology"; Course I, University of Nebraska College of Medicine, Omaha.

6-7 Annual Surgical Meeting (Tentative); Dr. M. Stanley, Louisville.

20-21 Postgraduate course, "Psychiatry"; University of Michigan Medical Center.

March

6-10 Postgraduate course, "Pediatrics"; University of Tennessee, Memphis.

8-9 Postgraduate course, "Hematology," (Tentative) Lexington, Ky.

9-10 Postgraduate course, "Infertility and Endocrinology"; University of Michigan Medical Center, Ann Arbor.

13-14 Postgraduate course, "Neurology, Clinical"; University of Michigan Medical Center.

15-17 Postgraduate course, "Anesthesiology"; University of Tennessee, Memphis.

16-17 Postgraduate course, "Gastroenterology"; University of Nebraska, College of Medicine, Omaha.

20 Senior Day Program—Sponsored by the KSMA, Jefferson County Medical Society, and the University of Louisville; afternoon and evening, Kentucky Hotel.

20-24 Postgraduate course, "Electrocardiography"; University of Tennessee, Memphis.

22-23 Symposium on Heart Disease, sponsored by the Heart Association, and the University of Louisville; Brown Hotel, Louisville.

23 Pediatric Society meeting; Louisville, Sheraton Hotel.

24 Postgraduate course, "Physical Medicine"; University of Nebraska College of Medicine, Omaha.

24-25 Kentucky Chapter, American College of Surgeons, Annual Meeting; Louisville, Brown Hotel.

30 Postgraduate course, "Obstetrics (Lincoln)"; University of Nebraska College of Medicine, Omaha.

April

3-5 Postgraduate course, "Radiology-Diagnostic"; University of Michigan Medical School Center, Ann Arbor.

3-7 Postgraduate course, "Diseases of the Blood"; University of Michigan Medical Center, Ann Arbor.

5-7 Postgraduate course, "Ob-Gyn"; University of Tennessee Medical School, Memphis.

6 County Society Officers Conference; Lexington, Phoenix Hotel.

7-12 Ohio State Medical Association Annual Meeting; Netherlands Hilton Hotel, Cincinnati.

7-12 Tennessee State Medical Association Meeting; Reed House, Chattanooga.

12-13 Postgraduate course, "Pediatrics" (Tentative), Owensboro.

13 Kentucky Academy of General Practice Seminar, Ashland.

13-15 Postgraduate course, "Allergy"; University of Michigan Medical Center, Ann Arbor.

14-15 Medical Legal Conference, sponsored by the AMA; Louisville.

17-18 Postgraduate course, "Pediatrics"; University of Nebraska, Omaha.

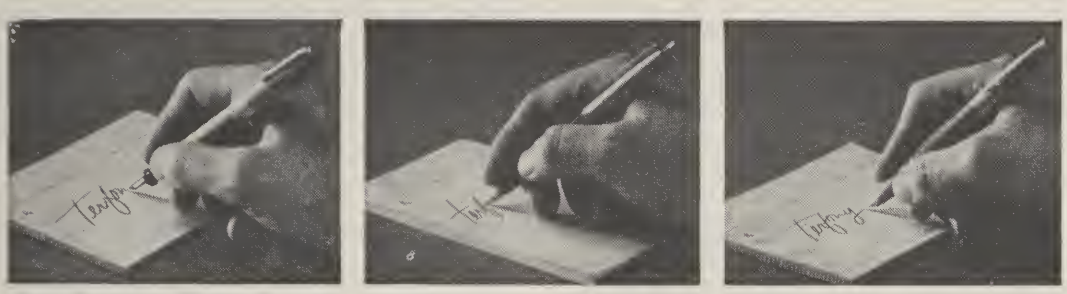
17-21 Postgraduate Course, "Endocrinology and Metabolism"; University of Michigan Medical Center, Ann Arbor.

20-23 Postgraduate course, "Otolaryngology"; University of Michigan Medical Center.

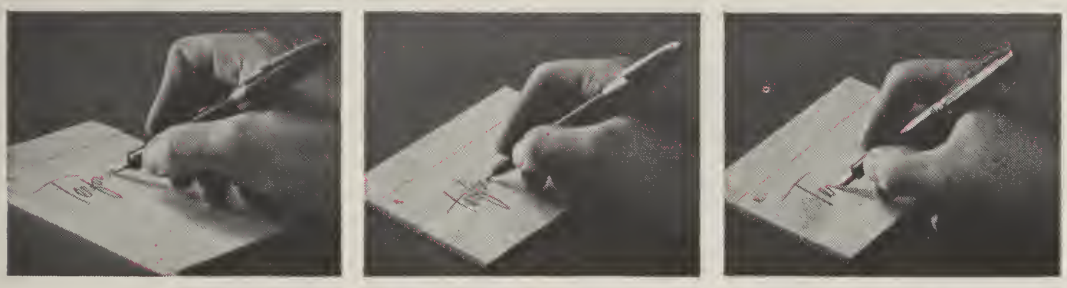
24-26 Postgraduate course, "Rheumatology"; University of Michigan Medical Center.

24-26 Postgraduate course, "Ophthalmology"; University of Michigan Medical Center.

24-28 Postgraduate course, "Recent Advances in Therapeutics"; University of Michigan Medical Center, Ann Arbor.



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County Society Reports

Bell County

The Bell County Medical Society elected the following officers at its annual Christmas dinner-meeting on December 7: President, Joseph Krakauer, M.D.; vice-president, Fred B. Weller, M.D., and secretary-treasurer, George Day, M.D.

McCracken County

"Tetanus—Present Concepts on Prophylaxis and Treatment," was the topic discussed by T. T. Myre, M.D., Paducah, during the scientific portion of the meeting of the McCracken County Medical Society at Boswell's Restaurant on November 16. William Myre, M.D., Paducah, presided at the short business meeting.

The legislative committee reported on several interesting comments on the recent elections—both on the local and national level. The Insurance Committee reported it was still studying the matter of covering the society as a group with Blue Cross programs.

Frank B. Crawford, M.D., was accepted for active membership unanimously. The Mental Health Committee was instructed to investigate the situation and problems arising with the Mental Health Clinic and to assist them in any way possible. The report of the meeting was submitted by Glenn R. Noss, M.D., Paducah, society secretary.

Mercer County

George F. Ballard, M.D., Harrodsburg, was elected president of the Mercer County Medical Society at a meeting at the Haggin Memorial Hospital on December 5. John S. Baughman, M.D., was named vice-president and C. B. Van Arsdall, M.D., was re-elected secretary-treasurer. Doctor Ballard was chosen delegate to the KSMA Annual Meeting, with Doctor Baughman as alternate. All are Harrodsburg physicians.

Muhlenberg County

R. E. Davis, M.D., Central City, was elected president of the Muhlenberg County Medical Society at a recent meeting. He succeeds G. L. Simpson, M.D., Greenville. Other officers named were J. N. Tulloh, M.D., Central City, vice-president; G. F. Brockman, M.D., Greenville, secretary-treasurer.

C. J. Shipp, M.D., Greenville, was elected delegate to the KSMA, and G. F. Brockman, M.D., Greenville, alternate delegate.

A report on the activities in the county during Diabetes Detection Week was made by R. E. Davis, M.D., chairman of the Diabetes Committee. Doctor Davis was commended on the activity of the committee.

A resolution urging an effort to acquaint physicians with opportunities for practice in the county was adopted unanimously.

Scott County

Members of the Scott County Medical Society were guests of the Scott County Bar Association at a dinner at the Spring Valley Country Club near Lexington in November.

Logan Gragg, M.D., superintendent of Eastern State Hospital, Lexington, spoke on mutual problems of doctors and lawyers, with special reference to mental health matters.

KSMA Council, Committee Reports

Council on Scientific Assembly

Gaithel Simpson, M.D., Vice-Chairman

Louisville **November 10, 1960**

The Council on Scientific Assembly met November 10 at the Brown Hotel, Louisville, in a luncheon session. After reviewing results of the 1960 Annual Meeting, the Council turned its attention to the 1961 meeting which will be held in Louisville, September 19, 20 and 21.

Detailed and routine procedures were settled and the Council began plans for the 1961 scientific program.

No change is planned in the operation of the specialty group sessions. A meeting of the presidents of the 13 groups cooperating with the KSMA meeting was called for January 5 to discuss procedures and lay plans.

After names of all 13 guest speakers and information on them are received, the program committee of the Council will meet to set up the scientific program.

Alcoholism Div. in State Dept.

A Division of Alcoholism in the State Department of Health was created in December to replace the Commission of Alcoholism. The new division will be directed by Richard B. Holt, M.D., deputy commissioner of health. Governor Combs also designated members of the commission as an advisory committee to the new division. Associate directors will be Dr. Raymond Forer, social psychologist, and Dr. Seymour Warkov, a medical sociologist, both on State Health Department staff.

In Memoriam

F. W. HINKLE, M.D.
Louisville
1887 - 1960

Ferdinand W. Hinkle, M.D., retired physician, died December 10 at Our Lady of the Angels Convalescent Home, Louisville. He was 83.

A native of Louisville, Doctor Hinkle returned there when he retired in 1952 after practicing in Atlanta. He served in the Army Medical Corps during World War I.

NEWS ITEMS

Eli C. Boggs, M.D., was one of four Hazard City Commissioners returned to office by executive order of Governor Combs on December 8. The Court of Appeals had stripped the four of their positions as City Commissioners on November 25. Before their election in 1959, they had pledged to donate their fees as city officials to different welfare needs, and the losing candidates for Commissioner accused them of violating the Corrupt Practice Act.

Jay C. Coulter, M.D., a graduate of the University of Virginia Medical School in 1907, has opened an office in Mayfield for the general practice of medicine. He formerly practiced in Charlottesville, Va. He took his internship training at Southside Hospital in Pittsburgh, and was associated with the Forsythe County Tuberculosis Hospital, Winston-Salem, N. C., for three years. Doctor Coulter is native of Pennsylvania.

William D. Shidal, M.D., has opened an office in the Medical Arts Building, Paducah, for the practice of pediatrics. He previously practiced three years at Elizabethtown. Born in Clinton, Ill., Doctor Shidal was graduated from the University of Louisville School of Medicine in 1953, interned at SS Mary & Elizabeth Hospital, Louisville, and took residency training at St. Joseph Infirmary, Louisville. He served three years in the U.S. Army Air Corps, attaining the rank of first lieutenant.

Theodore Thomas Myre, M.D., has started the practice of general medicine and thoracic surgery in Paducah, in association with **M. W. Fowler, Jr., M.D.** He formerly practiced at Evansville, Ind. A native Paducahan, Doctor Myre was graduated from Northwestern University Medical School in 1948. He served his internship and a year's residency in surgery with the Evanston Hospital Association, followed by residencies at the Mayo Foundation, Rochester, Minn., from 1950-51 and 1953-57. He served in the U. S. Air Force, 1951-53, with the rank of captain. Doctor Myre is a Diplomate of the American Board of Surgery and the Board of Thoracic Surgery.

Robert Taylor Peterson, Jr., M.D., has started practice in Fulton in association with **Glynn F. Bushart, M.D.; R. Ward Bushart, M.D.,** and **Thomas J. Lane, M.D.** A native of Rutherford, Tenn., Doctor Peterson received his M.D. degree from the University of Tennessee in 1959 and interned at John Gaston Hospital, Memphis. He served in the U. S. Navy from 1951 to 1955, with the rank of lieutenant.

Fred C. Rainey, M.D., has opened an office for the general practice of medicine in Elizabethtown. He was formerly associated with the Elizabethtown Clinic. A native of Tennessee, he graduated from the University of Tennessee Medical School in 1955 and interned at John Gaston Hospital.

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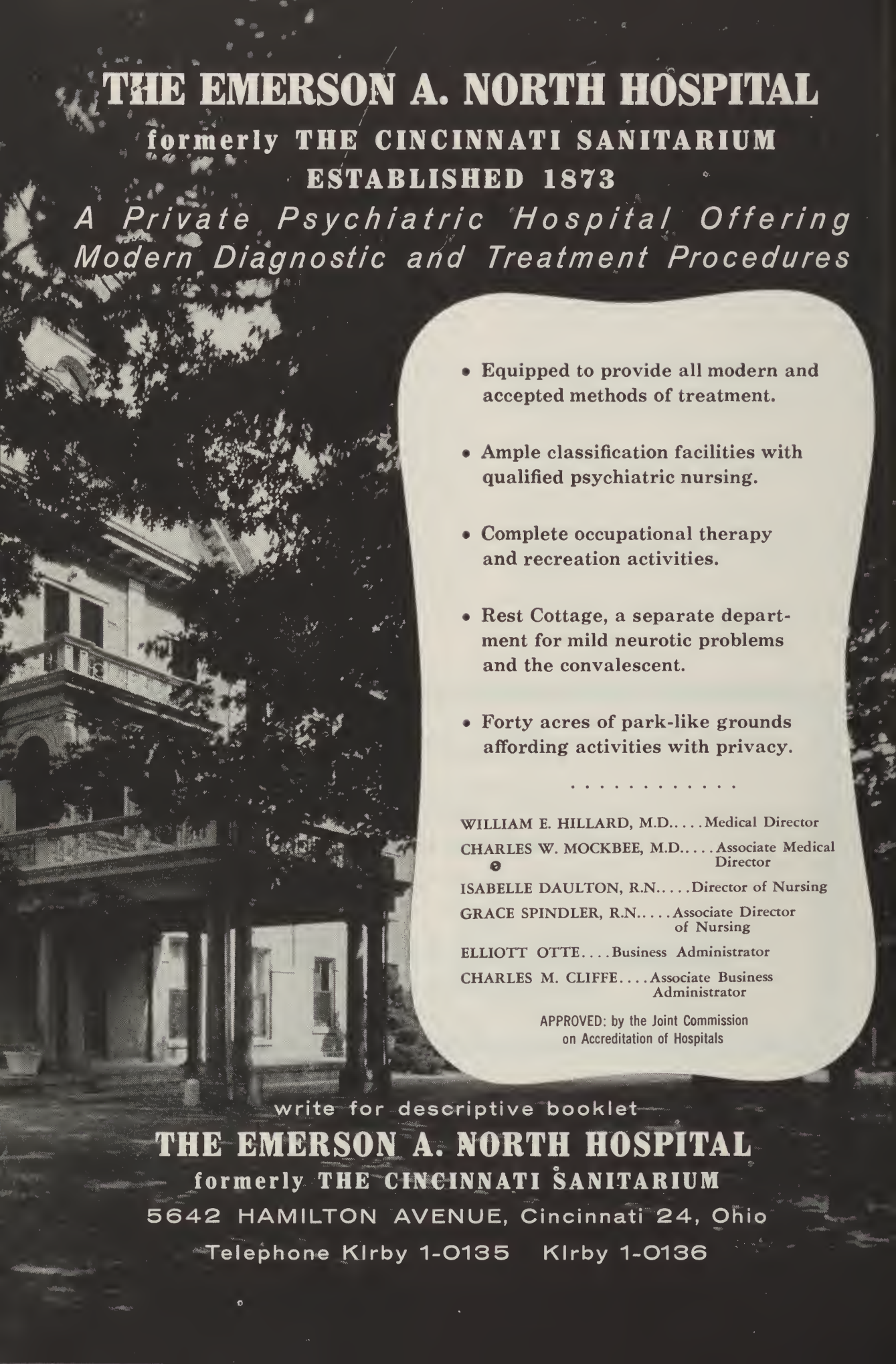
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NEWS ITEMS

Russell E. Teague, M.D., Kentucky's Commissioner of Health, addressed the National Conference on Water Pollution held in Washington, D. C., December 12-14. A member of the President's Water Pollution Control Advisory Board, Doctor Teague commented on a paper dealing with public health aspects of water pollution. The conference, called by Surgeon General Leroy E. Burney at the request of President Eisenhower, marked the beginning of a new national effort to curb water pollution.

Charles B. Wathen, M.D., has opened an office in Hardinsburg where he will limit his practice to surgery. A graduate of Washington University Medical School, St. Louis, in 1940, he took his residency training in surgery at Charity Hospital, New Orleans. He came to Hardinsburg from Owensboro where he has been associated with Breckinridge Memorial Hospital since 1948. He is a fellow of the American College of Surgeons.

The magic of radio has brought a new medical service to Ohio Countians. Members of the Ohio County Medical Society have equipped their cars with units which keep them in constant touch with the county hospital while they are out on calls. Installation of units in their homes is under consideration.

Robert Marvin Sigler, M.D., has started the practice of medicine in Albany in association with **Floyd B. Hay, M.D.** A native of Memphis, Tenn., Doctor Sigler received his M.D. degree from the University of Tennessee in 1956, interned at John Gaston Hospital, Memphis, and practiced at Campbell's Clinic Hospital, Chattanooga. He served two years, July 1958—July 1960, as a senior assistant surgeon in the U.S. Public Health Service.

G. W. White, M.D., Henderson, has retired after 51 years of practice, including 41 years as an eye, ear, nose and throat specialist. Native of the Providence community, Doctor White was graduated from the University of Louisville School of Medicine in 1908 and started practice in Providence. After 10 years, he went to Chicago to take training in his specialty. He opened his Henderson office in 1919 at the same location he occupied until his retirement.

"Living Conditions, Health and Economic Development," will be the title of the third International Conference of the International Medical Association for the Study of Living Conditions and Health planned for Sept. 29 and 30 and October 1 in St. Vincent, Aosta Valley, Italy. For further information write International Medical Asscciation for the Study of Living Conditions and Health, Vienna 7, Austria.

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PERTINENT PARAGRAPHS

A course of particular interest to general practitioners is being offered February 8 and 9 by the Frank E. Bunts Educational Institute affiliated with the Cleveland Clinic Foundation. The program, which is open to all members of the medical profession, is sponsored by the Cleveland Chapter of the American Academy of General Practice and will be held in the North Clinic Building, Cleveland.

The Board of Regents of the American College of Chest Physicians, meeting in Washington, D. C., on November 28, adopted a resolution to establish a relief fund for Cuban members of the College who have been exiled temporarily from their country. The Board voted to contribute $5,000 to launch the fund, and contributions are being solicited from College members and other interested persons, according to Murray Kornfeld, executive director of ACCP. The Cuban Chapter of the College was founded in 1940 and now has 74 members.

The New Orleans Graduate Medical Assembly is scheduled for March 6-9 with headquarters at the Roosevelt Hotel. Following the Assembly a clinical tour of the Orient has been scheduled with stops in Honolulu, Manila, Hong Kong, Tokyo, Miyanoshita, and Kyoto. For additional information write: New Orleans Graduate Medical Assembly, 1430 Tulane Avenue, New Orleans 12, La.

A record-breaking total of $800,000 was spent on arthritis research during the past year by the Arthritis and Rheumatism Foundation, according to that association's 12th annual report. This represents a rise of 40 per cent in a single year, the greatest increase since the organization was founded in 1948. Research money is used: (1) to support study of rheumatic disease by selected scientists and, (2) to provide grants-in-aid to institutions where such studies are carried on.

A five-day full-time course on surgery of the hand will be offered by the New York University Medical Center from March 6-11 under the direction of William T. Medl, M.D., and Thomas D. Rees, M.D. Sessions will consist of practical demonstrations, lectures, and panel discussions by members of the NYU faculty and a visiting faculty of eminent specialists in surgery of the hand. The class is limited to 40 and tuition is $125. For applications, write office of the Associate Dean, NYU Postgraduate Medical School, 550 First Ave., N. Y. 16, N. Y.

The West Virginia Academy of Ophthalmology and Otolaryngology will hold its annual meeting at the Greenbrier Hotel, White Sulphur Springs, W. Va., on April 6-8. Guest speakers will include Irving H. Leopold, M.D., Philadelphia; Harvey B. Thorpe, M.D., Pittsburgh; John J. Shea, M.D., Memphis, Tenn., and F. Johnson Putney, M.D., Philadelphia.



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Columbia Auditorium — **Louisville, Kentucky** — **September 19, 20 and 21**

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Committee on Scientific Exhibits

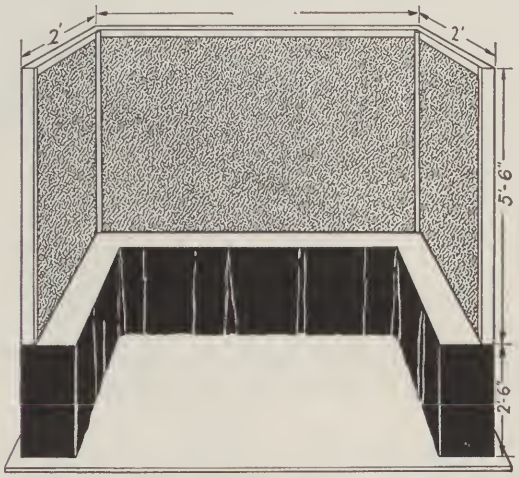
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5. Name of institution co-operating in the exhibit (if desired) .....

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The Kentucky State Medical Association will provide without cost to the exhibitor the following: Exhibit space, shelves, sign for booth, current, bracket lights, provided all items are approved in advance by the committee.

Cost of transporting exhibits to the meeting must be borne by the individual exhibitor as well as costs of cards, signs, etc., which are a part of the exhibit.

View boxes, furniture, decorations, etc., may be rented, if desired, by applying directly to Jos. T. Griffin Company, 704 West Main Street, Louisville 2, who supply equipment for the annual K.S.M.A. meeting.

WASHINGTON NEWS

(Continued from Page 16)

posal to require every package of drugs sold to pharmacies to contain an official brochure on their use and hazards. The AMA proposed instead that it be given the responsibility of getting such information directly to physicians.

•

FOREIGN INTERNS who failed medical examinations last September may remain in this country until at least next July 1.

In cooperation with the State Department, the AMA agreed to extend for six months a January 1 deadline for dismissal of foreign interns unless they pass the examinations through the Educational Council for Foreign Medical Graduates.

The flunking interns will be given another opportunity to take the examinations in April. Meantime, they must be taken off patient care and their hospitals must set up training programs for them.

The AMA Council on Medical Education and Hospitals said that this policy would be carried out judiciously and that occasional exceptions would be granted where circumstances warranted.

The American College of Allergists Graduate Instructional Course and Seventeenth Annual Congress is scheduled for March 12-17 at the Statler Hilton Hotel, Dallas, Texas. For information write: John D. Gillaspie, M.D., Treasurer, 2141 14th St., Boulder, Col.

Emergencies Topic of P. H. Course

"The Local Health Department in Emergencies" is the topic of a three-day baseline training course to be presented by the State Department of Health in cooperation with the U. S. Public Health Service in Frankfort on January 24-26. Although the course is designed primarily for the orientation and training of local health directors, a limited number of ancillary professional personnel are being invited to attend, including Richard G. Elliott, M.D., Lexington, KSMA president, and Morgan Colbert, M.D., Louisville, chairman of the committee on Emergency Medical Services.

AMEF Gets $277,602 From States

The American Medical Education Foundation received checks totaling $277,602.84 from seven state medical associations at the opening meeting of the House of Delegates during the Clinical Meeting of the AMA in Washington in December. State asssociations and the amounts donated are: California, $162,505; Alaska, $940; Arizona, $9,697.50; New Jersey, $30,429.34; Utah, $11,370; Indiana, $36,225; and New York, $26,436.

The Society of Nuclear Medicine has set June 14-21, 1961, as the date for its eighth annual meeting at the Penn Sheraton Hotel, Pittsburgh. For further information, address inquiries to Samuel N. Turiel, Administrator, Society of Nuclear Medicine, 430 N. Michigan Avenue, Chicago 11, Ill.

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IN THE BOOKS

THE LIST METHOD OF PSYCHOTHERAPY: by Elizabeth Sher, Eleanor Messing, Theodora Hirschhorn, Enis Post, Annette Davis and Arthur Messing; published by Philosophical Library, Inc., New York; 258 pages; price, $7.50.

This book was written as a tribute to Jacob S. List by a group of his former patients who are now educators.

It consists of the following articles describing the List philosophy of counseling: Therapist Selection and Training; Higher Education as Therapy; The Reception Room as Therapeutic Community; Family Resistance and Client Progress; Warmth in the Therapeutic Process; and Sexual Inversion and Re-orientation.

The List method is based on the premise that patterns of behavior are acquired in childhood and can be modified by emotional re-education. It requires a relatively high degree of intelligence in the patient, as he is encouraged to return to his academic studies.

This is a slight variation in the comprehensive problem of how to improve mental health. List incorporated the social aspects of family and community relationships into a therapeutic process with some success. The basic ideas of group therapy, environmental manipulation and social interaction are used to divert the patient's attention from his pathological problem. The "therapeutic community" of the office and waiting room become the substrate for therapy and "a program is substituted for a problem."

The ideas expressed here merit careful consideration, and could have been presented more adequately had not the authors been so defensive about their own inadequacies. Too much space is given to a multitude of quotations and references in an attempt to establish precedence for this technique.

Wilber A. Mitchell, M.D.

NINE MONTHS' READING: A MEDICAL GUIDE FOR PREGNANT WOMEN: by Robert E. Hall, M.D.; published by Doubleday & Company, Inc., New York, N. Y.; 1960; 191 pages; price, $2.95.

Dr. Hall has added another primer of obstetrics to the "how to have a baby" library of our patients. The book has many virtues. Outstanding is that the author has private patients and that he is aware of the pitfalls of the telephone and grandmother. Also, this book is written in a light, and many times humorous, vein. Pregnancy, labor, delivery and the puerperium in general are treated chapter by chapter as what they are—a phenomenon of nature—not a grave illness.

The complications of obstetrics are dealt with in a factual and reassuring manner that even the most apprehensive patient might find stimulating to read. The section on Natural Childbirth is skillfully written, and the middle road (Prepared Childbirth) is given its rightful preference in the management of labor and delivery.

Considerable space is devoted to the wonders of breast feeding of infants. It seems to this reader that some of these mothers who are unable to successfully suckle their young might experience the same disappointment and sense of failure that we have seen in the unsuccessful zealots of Natural Childbirth.

Certainly this book will handsomely supply the smatter that seems to be a requisite for so many of our patients to bring forth their young.

William E. Pugh, M.D.

PARDON MY SNEEZE: by Milton Millman, M.D.; published by Frye & Smith, Ltd., San Diego, Calif., 1960; 215 pages; price, $4.

This monograph is intended primarily for the allergic patient or for those responsible for his immediate care. The first edition was published in 1952. Sufficient interest apparently was evidenced to warrant this second presentation.

The book is well illustrated, and a number of the sketches are of humorous design. Some 114 pages deal with the definition, diagnosis, and treatment of allergic disease; the remaining 101 pages, a disproportionate number, deal with the subject of food allergy, recipes, and menus.

Of necessity such editions reflect the author's judgment and philosophy. For the lay reader, in dealing with the more controversial aspects of food allergy, a stricter adherence of neutrality might have been preferred. The dogmatic inclusion of food allergy as an important factor in practically all infant and adult allergic diseases would be challenged sharply if presented to a medical audience.

The author states that, "Sensitivity to corn is the most common cause of food allergy and, in general, corn is the most difficult food in the diet to avoid." Certainly this is not the opinion of most allergists. In fact, a number of years ago Dr. Mary Loveless, by means of disguised feedings of cereal pudding, showed that there is a very low incidence of allergy to corn cereal. Corn sugar, corn syrup, and corn oil certainly have shown an extremely low incidence of sensitivity, yet the author warns the patient to avoid all forms of corn and food products containing corn. Some three pages of such foods are listed as well as

(Continued on Page 90)

In over five years

Proven
in more than 750 published clinical studies

Effective
for relief of anxiety and tension

Outstandingly Safe

1. simple dosage schedule produces rapid, reliable tranquilization without unpredictable excitation
2. no cumulative effects, thus no need for difficult dosage readjustments
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Usual dosage: One or two 400 mg. tablets t.i.d.
Supplied: 400 mg. scored tablets, 200 mg. sugar-coated tablets.
Also as MEPROTABS* — 400 mg. *unmarked,* coated tablets; and as MEPROSPAN® — 400 mg. and 200 mg. *continuous release* capsules.

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of clinical use...



...for the tense and nervous patient

Despite the introduction in recent years of "new and different" tranquilizers, Miltown continues, quietly and steadfastly, to gain in acceptance. Meprobamate (Miltown) is prescribed by the medical profession more than any other tranquilizer in the world.

The reasons are not hard to find. Miltown is a ***known*** drug. Its few side effects have been fully reported. ***There are no surprises in store for either the patient or the physician.***

NEW analgesic

Kills pain



stops tension

For neuralgias, dysmenorrhea, upper respiratory distress, postsurgical conditions... new compound kills pain, stops tension, reduces fever—gives more complete relief than other analgesics.

Soma Compound is an entirely new, totally different analgesic combination that contains three drugs. First, Soma: a new type of analgesic that has proved to be highly effective in relieving both pain and tension.* Second, phenacetin: a "standard" analgesic and antipyretic. Third, caffeine: a safe, mild stimulant for elevation of mood. As a result, the patient gets more complete relief than he does with other analgesics.

Soma Compound is nonnarcotic and nonaddicting. It reduces pain perception without impairing the natural defense reflexes.*

NEW NONNARCOTIC ANALGESIC

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Composition: Soma (carisoprodol), 200 mg.; phenacetin, 160 mg.; caffeine, 32 mg.
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Supplied: Bottles of 50 apricot-colored, scored tablets.

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BOOSTS THE EFFECTIVENESS OF CODEINE: Soma Compound boosts the effectiveness of codeine. Therefore, only ¼ grain of codeine phosphate is supplied to relieve the more severe pain that usually requires ½ grain.

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Dosage: 1 or 2 tablets q.i.d.
Supplied: Bottles of 50 white, lozenge-shaped tablets; subject to Federal Narcotics Regulations.

References available on request.

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From the files of the
COMMITTEE FOR THE
STUDY OF MATERNAL MORTALITY



Case #68—1959:

The patient, a 34-year-old married white, gravida 13, para 12, consulted her physician initially in the eighth month of pregnancy and failed to return for further prenatal care. At the first visit she weighed 138 pounds; the urinalysis was negative and the blood pressure was 110/60. The date of the last menstrual period was not stated. Ten of her twelve liveborn children were living. No other information was recorded.

The patient was admitted to the hospital at 9:30 p.m. on July 21, 1959, having uterine contractions at 10 to 15 minute intervals. The cervix was not dilated. At 6:30 a.m. on July 22, she complained of nausea, and vomited. The first stage of labor lasted four hours. Phenergan and Demerol in unspecified doses were given during the first stage. The membranes ruptured spontaneously at an unspecified time.

At 7:30 a.m., she exhibited profuse vaginal bleeding and the pulse became weak and rapid; the patient complained of severe thirst and marked abdominal distention. She was taken immediately to the delivery room where at 8:07 a.m. a 7 pound 6 ounce male stillborn infant was delivered by low forceps extraction. The type of anesthesia was not specified. The placenta was expelled at 8:11 a.m. together with much clotted blood; profuse uterine bleeding continued. Ergotrate and pitocin were given intramuscularly, and the ergotrate dose was repeated intravenously. The patient was returned to her room and an unsuccessful attempt was made to start an intravenous infusion. The blood pressure could not be obtained. Hemorrhage continued, and the patient expired at 8:45 a.m.

There was no autopsy. The cause of death on the certificate was given as placenta previa, even though no such clinical diagnosis had been made.

Comments

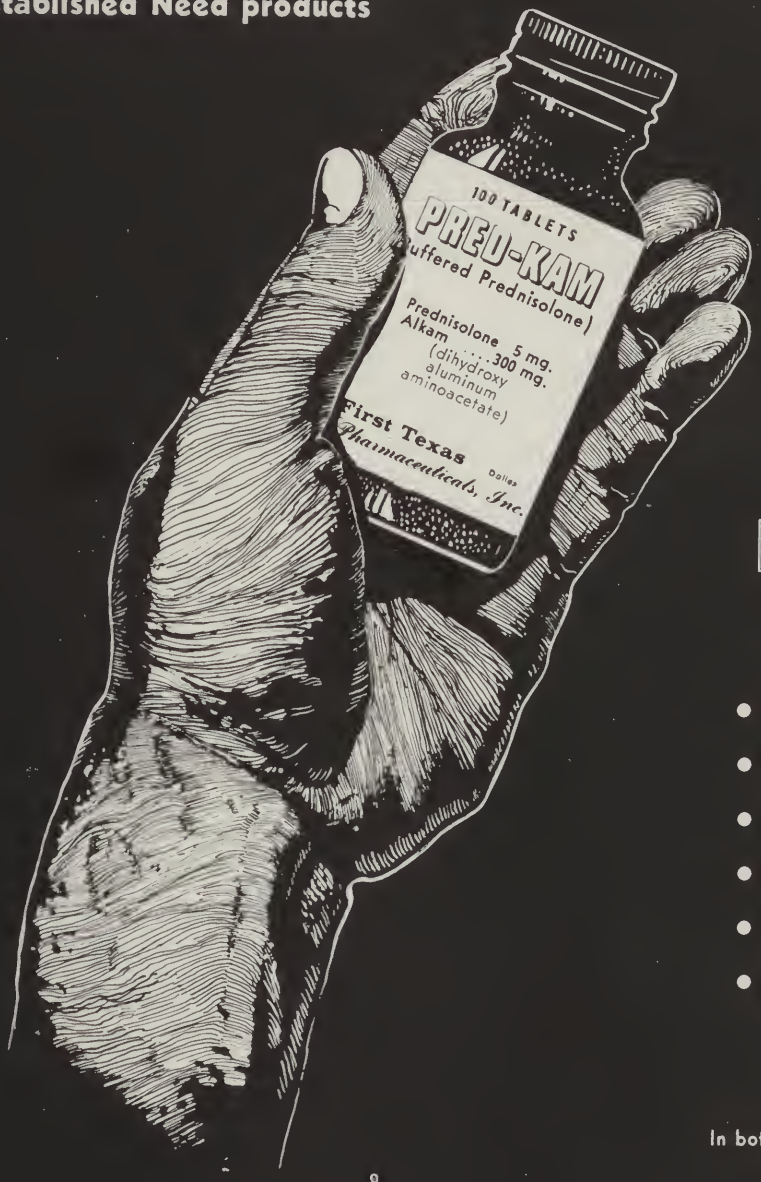
The Committee believed that the information provided clearly indicated that the cause of death stated on the certificate was incorrect. The correct diagnosis was probably abruptio placentae.

Several preventable features were involved in this obstetric death. The patient was returned to her room before the source of the bleeding had been determined. From the information supplied, the onset of the "profuse vaginal bleeding" was not followed promptly by vigorous measures for combating hemorrhage and shock. A pitocin infusion should have been started at the time of the onset of the bleeding; even if this were not necessary for increasing the strength of the uterine contractions, it ought to have been utilized to avert the strong possibility of postpartum hemorrhage due to uterine inertia. In the absence of autopsy findings, the Committee could suggest several possible reasons for this exsanguination. With abdominal distention and sudden shock as evidenced by the weak, rapid pulse, thirst and marked perspiration, spontaneous rupture of the uterus could not be ruled out.

The case focuses attention on obstetric hemorrhage, the most frequent cause of maternal death. This potentially fatal complication could be prevented if every obstetric patient were to come to labor and delivery with an adequate blood count, and if prompt steps were taken to diagnose and treat hemorrhage as soon as it occurs. If traumatic lacerations of uterus, cervix and vagina are ruled out by direct examination, the most likely cause of postpartum hemorrhage is uterine inertia. Oxytocic stimulation and manual massage may secure prompt hemostasis, and exsanguination will be delayed by immediate administration of whole blood. If positive, purposeful measures are not undertaken within a few minutes of the onset of the bleeding, the patient may well lose her life, as was indeed the case in the patient in question.

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PUBLIC HEALTH PAGE

Alcoholism Control

RUSSELL E. TEAGUE, M.D., M.P.H. *Commissioner of Health Commonwealth of Kentucky*

THE Governor's executive order creating a Division of Alcoholism Control in the Department of Health was announced recently. This division will assume the functions formerly fulfilled by the Commission on Alcoholism, including the basic program areas of research, treatment, rehabilitation and public education. The transfer of this program to the Department of Health reflects the growing recognition of alcoholism as a public health problem which merits sustained broad-gauged effort on the part of community agencies.

As a phenomenon of great complexity historically subject to misconceptions and stigma, a concentrated effort is required to measure, interpret and treat this illness and the numerous problems which precede, attend and result from its course of development. As defined by the World Health Organization, alcoholics are

> "excessive drinkers whose dependence upon alcohol has attained such a degree that it shows noticeable mental disturbance, or an interference with their bodily and mental health, their interpersonal relations and their smooth social and economic functioning; or who show prodromal signs of such developments."

The etiology and symptomatology of alcoholism involve physiologic, psychologic and social environmental factors, but precision in specifying the relative contribution of these factors cannot be attained without additional scientific investigation and advancement.

Alcoholism ranks high among the serious public health problems facing the country and the State of Kentucky. It has been estimated that over 60,000 alcoholics in various phases of alcohol-involvement are to be found among the population of this state, many of whom could benefit from facilities and skills, both present and potentially available.

The past two decades have witnessed striking changes in attitudes concerning treatment and rehabilitation of alcoholics. Formerly, alcoholism was perceived as a failing, primarily due to perversity and lack of will power. This attitude provoked societal responses leading to ostracism for many. Today, it is increasingly recognized that with medical, psychological and spiritual assistance, various types of alcoholic patients may be restored to their former positions in the family, at work, and in the community.

Medical and related scientists and lay groups, especially Alcoholics Anonymous, have played a most important role in changing attitudes toward the alcoholic patient. Also, studies, experiments and observations have led to the increasingly accepted concept that alcoholism is a disease and should be treated as such.

Physicians generally accept this development and they can do much for alcoholics and their families by offering professional and personal support of treatment and rehabilitation. Continued valuable assistance can be rendered jointly with Alcoholics Anonymous, church and civic groups and health agencies in the community.

Further changes in orientation regarding the desirability of treating alcoholics is necessary before a significant number of physicians will expand their practice to include this type of patient. Emerging concepts of comprehensive medical care delivered by a health team may facilitate such a development. Active participation in the treatment of an alcoholic has led to a growing recognition of the role of the hospital in such a program as well.

The American Medical Association and the American Hospital Association both have urged that a general hospital admit alcoholic patients under the care of physicians. There is some indication that special hospital facilities are not necessary for treatment except for a few unusually disturbed patients.

The role played by the Division of Alcoholism Control in the Department of Health will be fruitless without the active participation of physicians. The immediate need should be directed toward improving the possibility of rehabilitating the present group of alcoholics. The projected program should participate in further studies of the etiology of alcoholism and activities directed toward the prevention of this most important disease.

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You will find this book invaluable for treating patients with elevated serum cholesterol.

Complete menus for 10 days enable you to prescribe diets which are appetizing, nutritiously adequate and which can exert cholesterol depressant activity. Special attention has been given to constructing the menu patterns so that they adhere as closely as permissible to the patient's normal eating habits.

NRC Standards fulfilled. Each menu has been calculated to provide the proper daily allowance of proteins, vitamins and other nutrients as recommended by the Food and Nutrition Board of the National Research Council.

Weight control is achieved as each day's menu is given at 3 calorie levels—1200, 1800 and 2600 calories. You prescribe the level most desirable and modify as desired.

Variety and appetite appeal for patient are built into the menu plan to an extent not previously accomplished. Alternate choices for main dishes minimize monotony, encourage the patient to follow closely the menu plan you specify.

Complete recipes—65 in all—are included to assure that the specified menus provide prescribed levels of calories, the pre-determined ratio of poly-unsaturated to saturated fat, plus essential nutrients.

Dietary fat is controlled so that approximately 36% of the total calories are derived from fat and at least 40% of these fat calories are from poly-unsaturated components (linoleates) as found in pure vegetable oil. The replacement of saturated dietary fat by this percentage of poly-unsaturated fat has been found in clinical studies most effective in the reduction of serum cholesterol and in its maintenance at desirable levels. More liberal menus are provided for maintenance after the patient's progress indicates that desired therapeutic results have been accomplished.

Family meal preparation is simplified. The menus are planned around favorite foods having wide appetite appeal for all members of the household. Patients can entertain in comfort—enjoy cakes, cookies, snacks, prepared with recipes which meet medical requirements.

A high degree of satiety is achieved even at the lower calorie levels, because Wesson provides an unexcelled source of concentrated, slow-burning food energy.

Adaptable for use with diabetics. Carbohydrates have been calculated to fall within the acceptable range for patients to whom a diet planned for diabetes is important. Calories, which must be supplied from fat when the carbohydrate intake is limited, are provided by desirable poly-unsaturated vegetable oil.

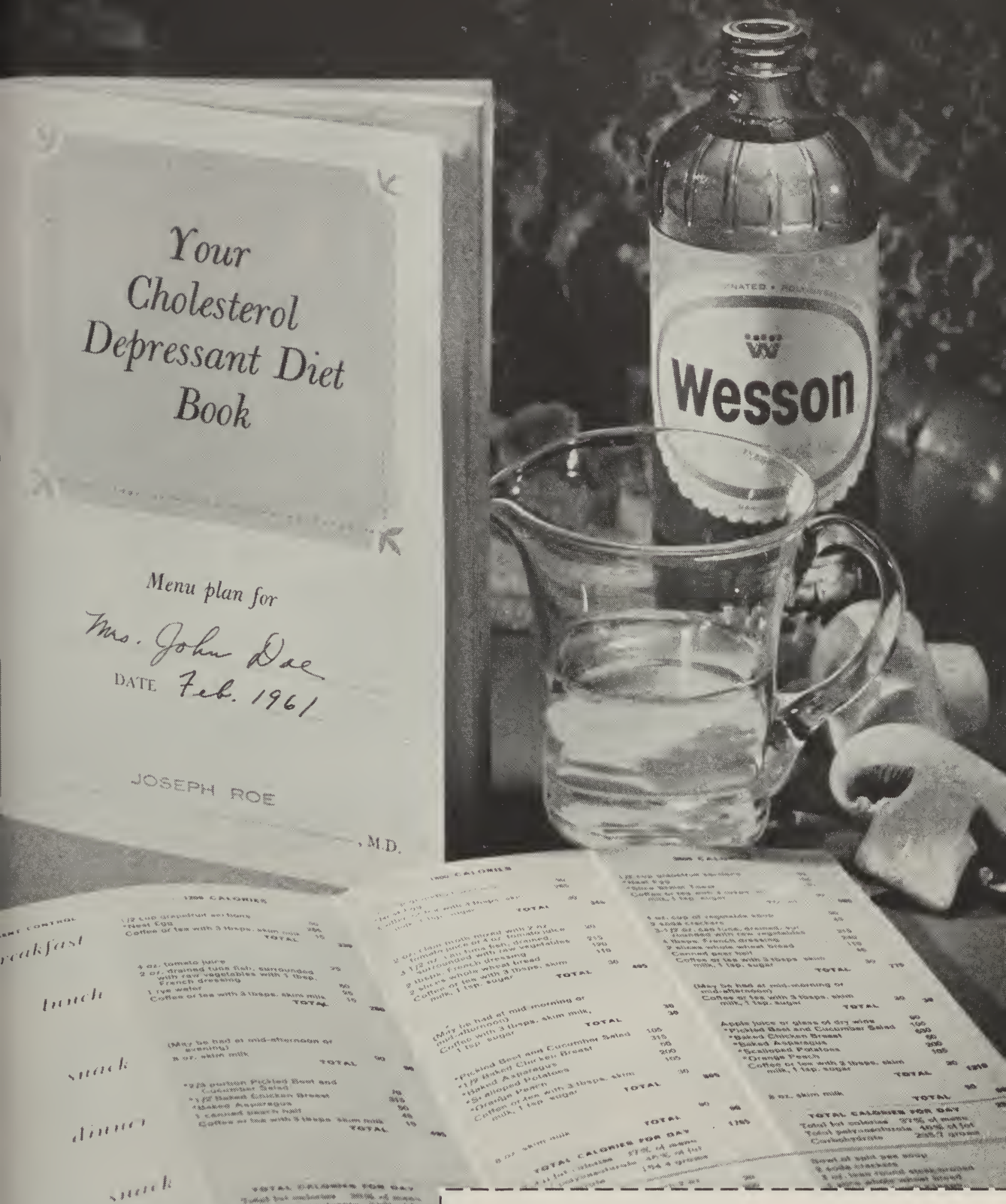
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Total unsaturated	70-75%
Palmitic, stearic and myristic glycerides (saturated)	25-30%
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Never hydrogenated—completely salt free

Poly-unsaturated Wesson is unsurpassed by any readily available brand, where a vegetable (salad) oil is medically recommended for a cholesterol depressant regimen.



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Neo-Synephrine hydrochloride relieves the boggy feeling of colds immediately and safely, without causing systemic toxicity or chemical harm to nasal membranes. Turbinates shrink, sinus ostia open, ventilation and drainage resume, and mouth-breathing is no longer necessary.

Gentle Neo-Synephrine shrinks nasal membranes for from two to three hours without stinging or harming delicate respiratory tissues. Post-therapeutic turgescence is minimal. Neo-Synephrine does not lose its effectiveness with repeated applications nor does it cause central nervous stimulation, jitters, insomnia or tachycardia.

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DEPRESSIONS *in private practice*

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This timely teaching film is now available for showing to interested professional groups.

The film describes and illustrates the signs of depressions commonly seen in general medical practice, and outlines suggested plans of treatment by the family physician. Suggestions are given on methods of handling suicide risk, referral, treatment in consultation, and hospitalization.

The film is black and white, sound-on-film, runs about 20 minutes and contains no commercial material.

To arrange for a group showing, please write the date you wish to show the film (list alternate dates, if possible) and the number of physicians expected to attend.

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IN THE BOOKS

(Continued from Page 77)

one page of corn-free products. Upjohn's "Abergic" line of drugs and some products of two other pharmaceutical companies are listed as free of corn.

Patients are repeatedly warned of the necessity of strict adherence to rigid diets. Food allergy even in adults is considered as of frequent occurrence. In fact, such sensitivity in adults is infrequent and is more often recognized by the patient rather than demonstrated by the physician. The author's overemphasis of food allergy easily might produce undesirable neuroses in susceptible individuals.

I feel that this book will not help your allergic patient significantly either in the understanding or in the treatment of his disease.

Armand E. Cohen, M.D.

CURRENT THERAPY—1960: edited by Howard F. Conn, M.D.; published by W. B. Saunders Company, Philadelphia and London; 808 pages; price, $12.

Each volume of "Current Therapy" seems to be better than the last. The present edition has been brought up to date with the addition of new treatments, discarding of the outmoded and retention of the proven and still most effective modes of therapy.

This year's volume is strictly up to date where recent developments have produced an advance. However, in all the cases, the best treatment has been included regardless of date of origin. In addition, there are but a few deletions and many additions of topics of timely nature. This new volume gives one the best treatment available today for every disease or disorder likely to be met.

The articles are all original, written exclusively for this volume. It is of importance that the information contained is not in any way experimental nor seemingly prejudiced in favor of any drug or method. The treatment is included solely because it is the most effective, whether new or old.

Carroll L. Witten, M.D.

Books Received

The following books have been received from publishers recently for review in *The Journal*:

A SYSTEM OF MEDICAL HYPNOSIS: by Ainslie Meares, M.D.; published by W. B. Saunders Company, Philadelphia and London.

COMPLICATIONS IN SURGERY AND THEIR MANAGEMENT: by Curtis P. Artz, M.D., F.A.C.S., and James D. Hardy, M.D., F.A.C.S.; published by W. B. Saunders Company, Philadelphia and London.

THE QUESTION OF FERTILITY: by Georges Valensin, M.D.; published by Doubleday & Company, Inc., Garden City, N. Y.

OBSTETRICS: by J. P. Greenhill, M.D., F.A.C.S.; published by W. B. Saunders Company, Philadelphia and London.



FIORINAL®

relieves pain,
muscle spasm,
nervous tension

rapid action • non-narcotic • economical

"We have found caffeine, used in combination with acetylsalicylic acid, acetophenetidin, and isobutylallylbarbituric acid, [Fiorinal] to be one of the most effective medicaments for the symptomatic treatment of headache due to tension."

Friedman, A. P., and Merritt, H. H.: J.A.M.A. *163*:1111 (Mar. 30) 1957.

ailable: Fiorinal Tablets and
v Form — Fiorinal Capsules

Each contains: Sandoptal (Allylbarbituric Acid N.F. X) 50 mg. (3/4 gr.), caffeine 40 mg. (2/3 gr.), acetylsalicylic acid 200 mg. (3 gr.), acetophenetidin 130 mg. (2 gr.).

Dosage: 1 or 2 every four hours, according to need, up to 6 per day.

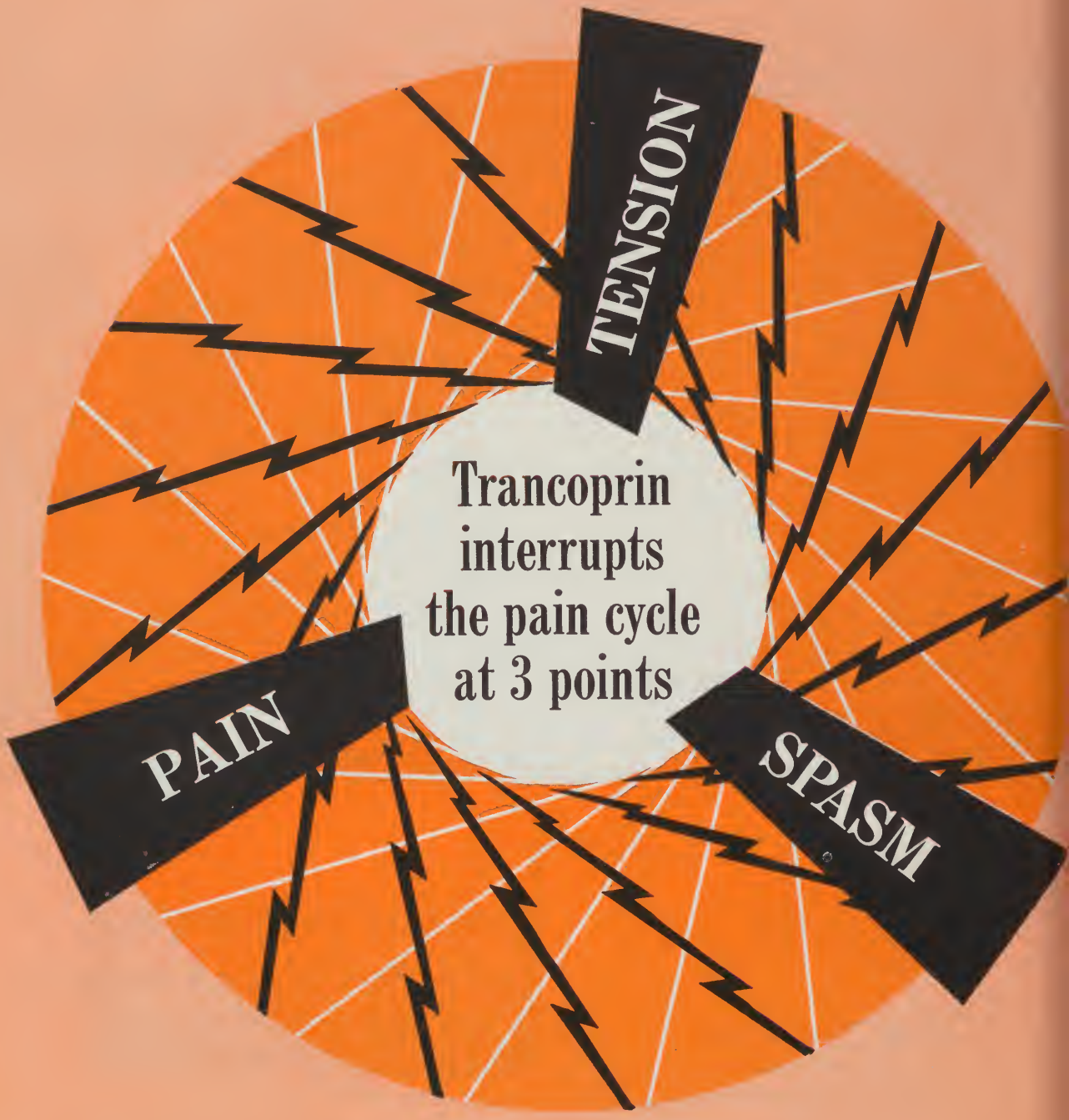
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acetylsalicylic acid (300 mg.) and chlormezanone (50 mg.)

Tablets



a broad spectrum non-narcotic analgesic

Trancoprin, a new analgesic, not only raises the pain perception threshold but, through its chlormezanone component, also relaxes skeletal muscle spasm[1-6] and quiets the psyche.[2,3-5,7]

The effectiveness of Trancoprin has been demonstrated clinically[8] in a number of patients with a wide variety of painful disorders ranging from headache, dysmenorrhea and lumbago to arthritis and sciatica. In a series of 862 patients,[8] Trancoprin brought excellent or good relief of pain to 88 per cent of the group. In another series,[9] Trancoprin was administered in an industrial dispensary to 61 patients with headache, bursitis, neuritis or arthritis. The excellent results obtained prompted the prediction that Trancoprin "... will prove a valuable and safe drug for the industrial physician."[9]

Exceptionally Safe

No serious side effects have been encountered with Trancoprin. Of 923 patients treated with Trancoprin, only 22 (2.4 per cent) experienced any side effects.[8,9] In every instance, these reactions, which included temporary gastric distress, weakness or sedation, were mild and easily reversed.

Indications

Trancoprin is recommended for more comprehensive control of the pain complex (pain → tension → spasm) in those disorders in which tension and spasm are complicating factors, such as: headaches, including tension headaches / premenstrual tension and dysmenorrhea / low back pain, sciatica, lumbago / musculoskeletal pain associated with strains or sprains, myositis, fibrositis, bursitis, trauma, disc syndrome and myalgia / arthritis (rheumatoid or hypertrophic) / torticollis / neuralgia.

Dosage

The usual adult dosage is 2 Trancoprin tablets three or four times daily. The dosage for children from 5 to 12 years of age is 1 tablet three or four times daily. Trancoprin is so well tolerated that it may be taken on an empty stomach for quickest effect. The relief of symptoms is apparent in from fifteen to thirty minutes after administration and may last up to six hours or longer.

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Each Trancoprin tablet contains 300 mg. (5 grains) of acetylsalicylic acid and 50 mg. of chlormezanone [Trancopal® brand]. Bottles of 100 and 1000.

Trancoprin Tablets / non-narcotic analgesic

References: 1. DeNyse, D. L.: *M. Times* 87:1512, Nov., 1959. 2. Ganz, S. E.: *J. Indiana M. A.* 52:1134, July, 1959. 3. Gruenberg, Friedrich: *Current Therap. Res.* 2:1, Jan., 1960. 4. Kearney, R. D.: *Current Therap. Res.* 2:127, April, 1960. 5. Lichtman, A. L.: *Kentucky Acad. Gen. Pract. J.* 4:28, Oct., 1958. 6. Mullin, W. G., and Epifano, Leonard: *Am. Pract. & Digest Treat.* 10:1743, Oct., 1959. 7. Shanaphy, J. F.: *Current Therap. Res.* 1:59, Oct., 1959. 8. Collective Study, Department of Medical Research, Winthrop Laboratories. 9. Hergesheimer, L. H.: An evaluation of a muscle relaxant (Trancopal) alone and with aspirin (Trancoprin) in an industrial medical practice, to be submitted.

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Clark treated 31 anginal patients who showed signs of anxiety, fear, excitement and other forms of emotional stress. On CARTRAX, all 31 fared better than they had on previous therapy... as judged both by subjective reports and by reduced nitroglycerin requirements.*

CARTRAX combines PETN (for prolonged vasodilation) with ATARAX (the tranquilizer preferred for angina patients because of its safety and mild antiarrhythmic properties). Thus, CARTRAX helps you to cope with both components of angina pectoris—circulatory **and** emotional.

For a better way to help your angina patients relax, prescribe CARTRAX.

*Clark, T. E., in press.

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PETN† + ATARAX®†† **Dosage:** Begin with 1 to 2 yellow CARTRAX "10" tablets (10 mg. PETN plus 10 mg. ATARAX) 3 to 4 times daily. For dosage flexibility, CARTRAX "20" (pink) tablets (20 mg. PETN plus 10 mg. ATARAX) may be utilized at a level of one tablet three to four times a day. The tablets should be administered before meals for optimal response. For convenience, write "CARTRAX 10" or "CARTRAX 20." As with all nitrates, use with caution in glaucoma. **Supplied:** In bottles of 100. Prescription only.

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THE COMPLETE Rx FOR COUGH CONTROL

cough sedative | antihistamine
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■ relieves cough and associated symptoms in 15-20 minutes. ■ effective for 6 hours or longer ■ promotes expectoration ■ rarely constipates ■ agreeably cherry-flavored

Each teaspoonful (5 cc.) of HYCOMINE* Syrup contains:

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Pyrilamine Maleate		12.5 mg.
Phenylephrine Hydrochloride		10 mg.
Ammonium Chloride		60 mg.
Sodium Citrate		85 mg.

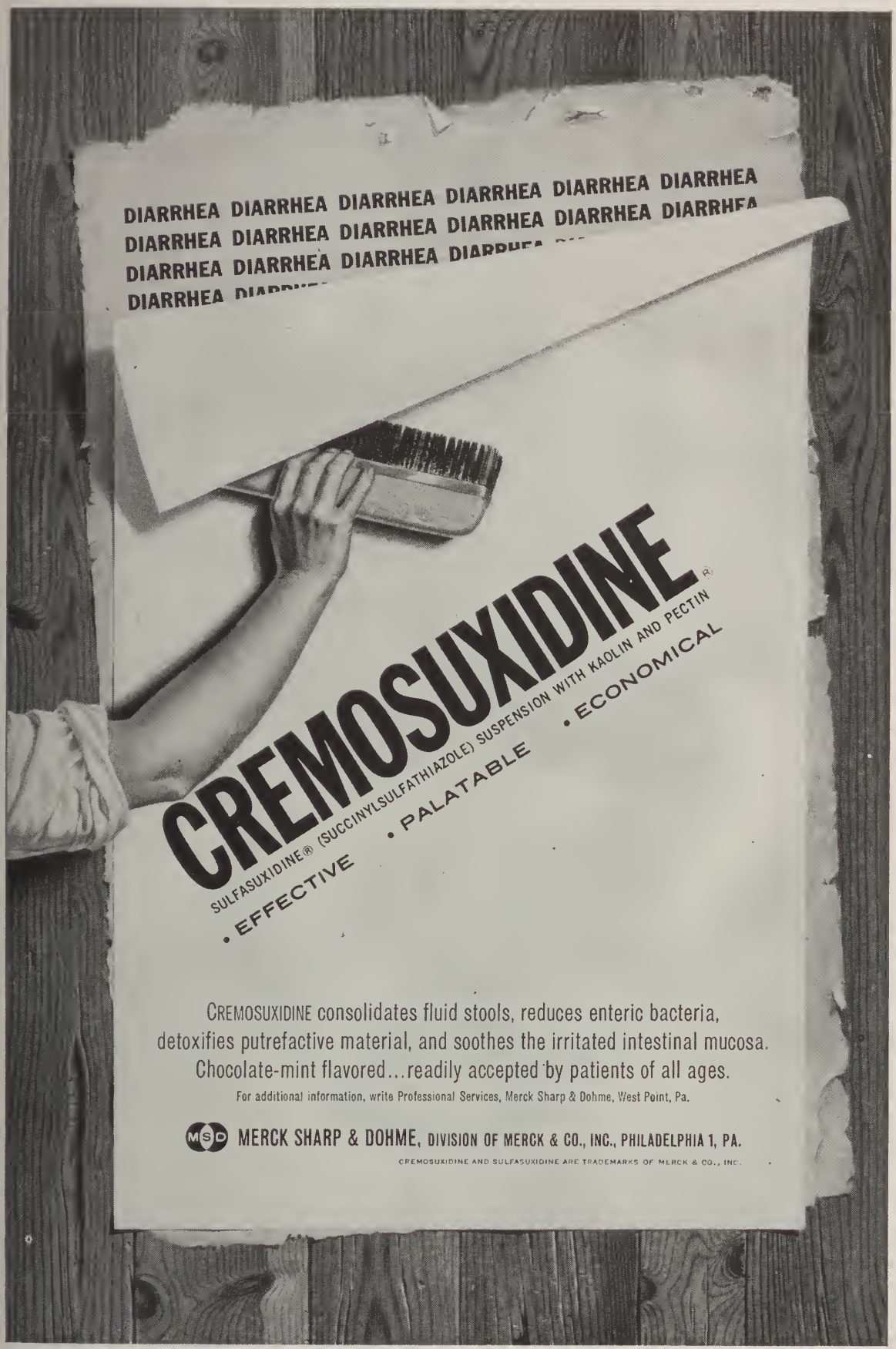
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References: 1. David, N. A.; Porter, G. A., and Gray, R. H.: Monographs an Therapy 5:60 (Feb.) 1960. 2. Ford, R. V.: Current Therap. Res. 2:92 (Mar.) 1960.

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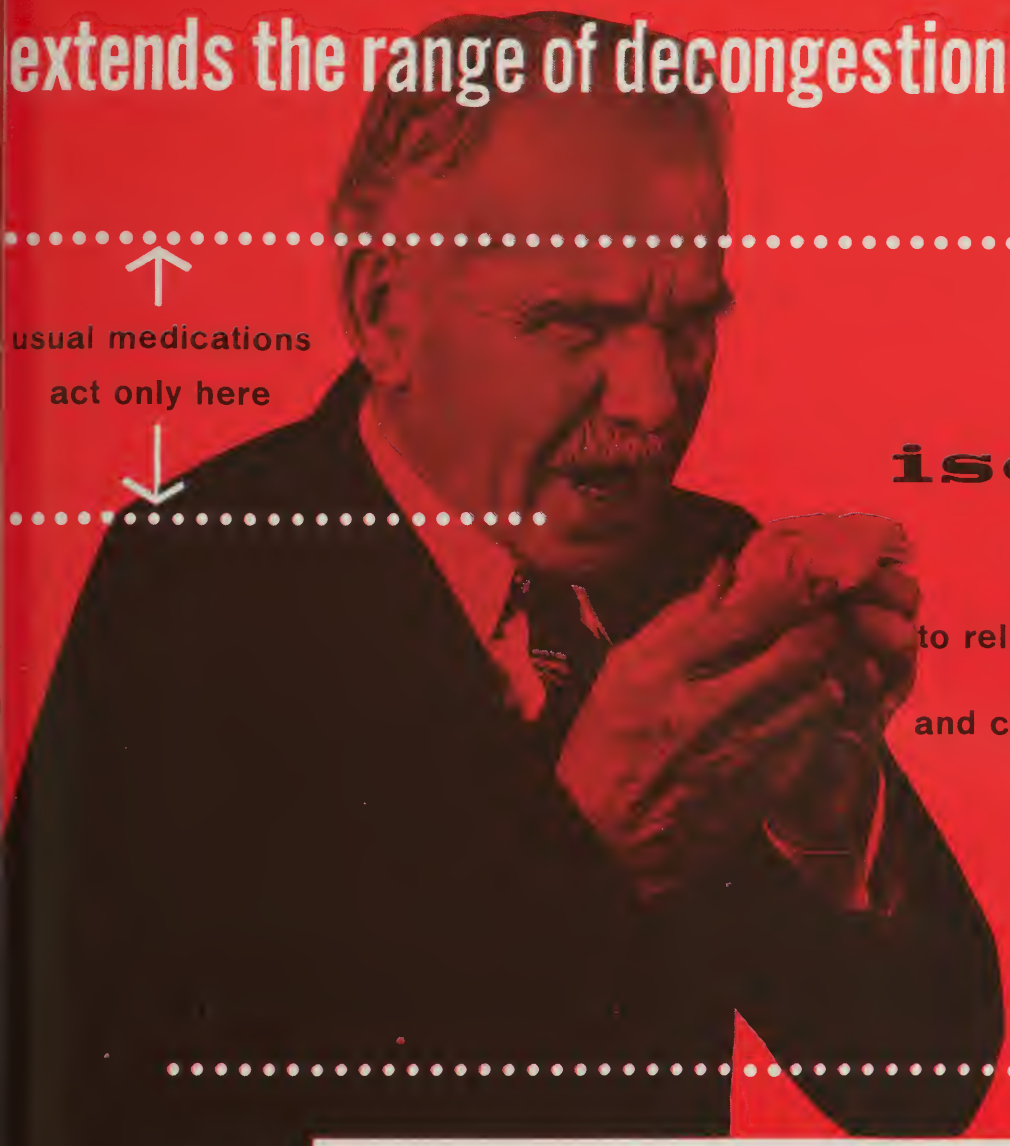
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1. Aviado, D. M. et al: J. Pharmacol. & Exper. Therap. 122: 406-417 (Mar.) 1958. 2. Laboratory Report: Research Div., Chas. C. Haskell & Co., 1959.

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Dr. Rees Receives Cancer Grant

E. D. Rees, M.D., of the University of Kentucky, Lexington, recently received a grant of $25,775 from the National Cancer Institute, according to an announcement by the Public Health Service. Doctor Ree's grant was for the study of "Genesis and metabolism of an induced mammary tumor." Approximately 150 projects concerned with a viral cause of cancer are now being supported in this country and abroad by grants from the Institute totaling more than $5.6 million.

The World Medical Association has announced a 38-day special cruise of the West Indies and South America in connection with its 15th General Assembly in Rio de Janeiro, Brazil, in September, 1961. The luxury cruise liner, the S. S. Argentina, is tentatively scheduled to leave New York September 15 and return October 24. Reservations may be made through the Travel Department, U.S. Committee, Inc., World Medical Association, 10 Columbus Circle, New York 19, N.Y.

The fourth International Congress of Allergology will be held at the Hotel Commodore, New York City, from October 15-20, 1961. Physicians from all parts of the world have been invited to take part in conferences, symposia, and panel discussions. For additional information, contact William B. Sherman, M.D., 60 East 58th St., New York 22, N. Y.

Wisconsin Opportunity Open

The Department of Administration of Wisconsin is seeking a physician qualified to fill the office of Director of Community Mental Health Services for the State's Division of Mental Hygiene. One of the duties would be the development of a community mental health consultant service. The salary starts at $19,860, ranges to $21,660. Requirements include work in a child psychiatry training program or two years in a community mental health or clinic program. Write: Dr. Leonard J. Ganser, Director, 1552 University Avenue, Madison, Wis.

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References: 1. Pitts, R. F., Am. J. Med., 24:745, 1958. 2. Ford, R. V., Cur. Therap. Res., 2:51, 1960.

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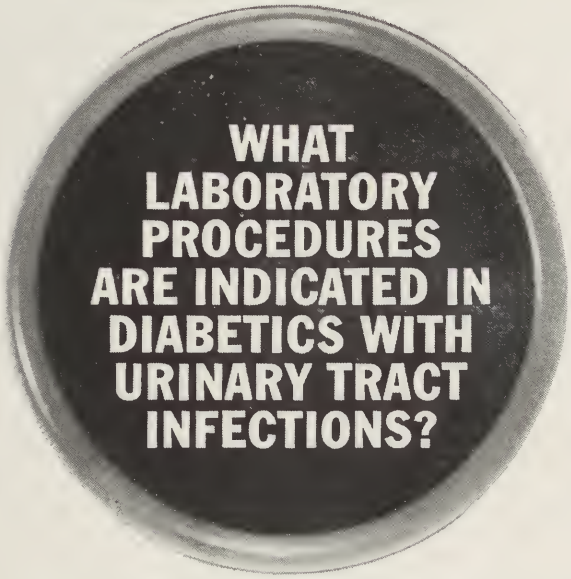
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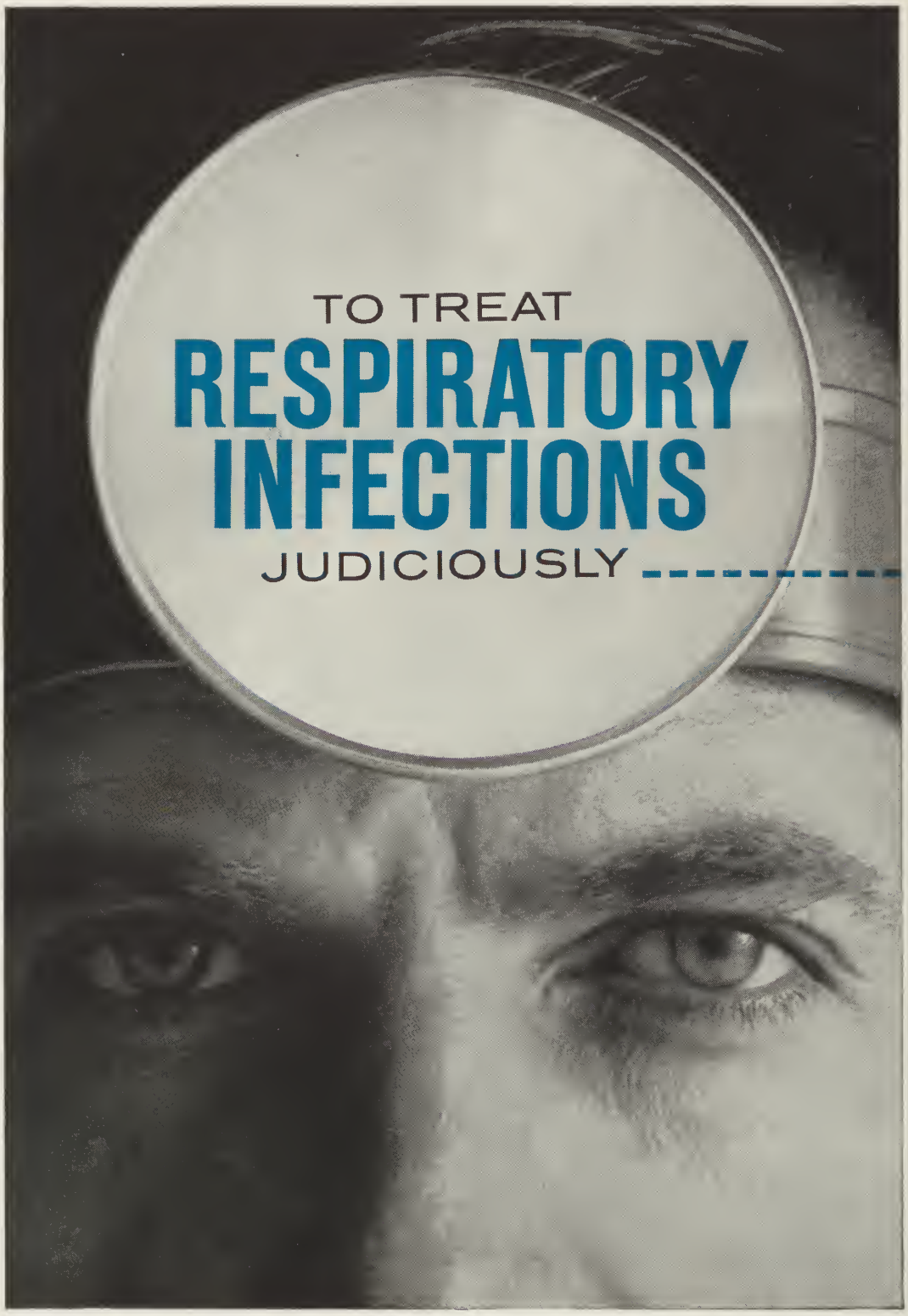
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President's Page*

THE ideal American family is founded on love. It is disciplined, enlightened and cohesive. It is a core of democracy, a stage for freedom, a school for social consciousness and a court of justice. It fashions the social order and fosters national greatness. Members shoulder responsibilities and share privileges and pleasures; they respect and encourage individual differences but exhibit unity and harmony.

The individual does not choose his family relations and he cannot completely sever his ties. His attitudes and actions alter, mold, enrich or destroy the pattern and quality of his family portrait. Heirs of an honorable family inherit privileges, powers, duties and responsibilities that must be preserved and enhanced; their position demands leadership, vision, courage, cooperation and action.

Our Medical family is founded on love—humanitarian ideals. It is large, diversified and honorable. Members should work to harmonize interests and concerns, objectives and designs to preserve and enhance our heritage — our democracy, in cooperation with our fellow citizens. We must oppose false ideologies, adverse and curtailing legislation, and socialistic trends that foster a welfare state. And we must study and work constructively, that we may recognize truth, analyze plans and evaluate movements correctly.

Organized medicine, and the Auxiliary, in its effort to influence and fashion medical legislation, must be keenly sensitive concerning family needs, desires and relations—and the total social, cultural and economic picture. No heir can afford to become engrossed. All must cooperate, if we are to initiate, create and establish policies and procedures to advance medicine, research, medical education, and a desirable and feasible National Health Program that may be approved by elected political leaders and representatives.

We need the discipline, the knowledge and vision, and the cohesive strength of our total family membership. The truth we unveil we must broadcast in word and deed. The fallacies we detect we must correct and counter-balance. The good we witness we must nourish—within and without our family circle.

Doctors' wives are members of our honorable family. We can be effective and influential. The Auxiliary can help us perform. But the Auxiliary branch of the family needs and deserves 100 per cent cooperation and support.

We need new Auxiliaries throughout the state, if we are successfully to cultivate friendly relations and promote mutual understanding among physicians' families. We need the weight of numbers to expedite organized medicine's legislative program through our Auxiliary Key-Contact Legislative System—if we would successfully promote the family's Health Careers Recruitment plan, its rural and mental health programs.

The attitudes and actions of doctors' wives are significant factors in family relationships—and in society. Among them and within the large family, there is no room for selfishness, isolation, indifference or discord. All cannot be active leaders, but they can support those who do accept the duties and responsibilities portioned them by the family councilors.

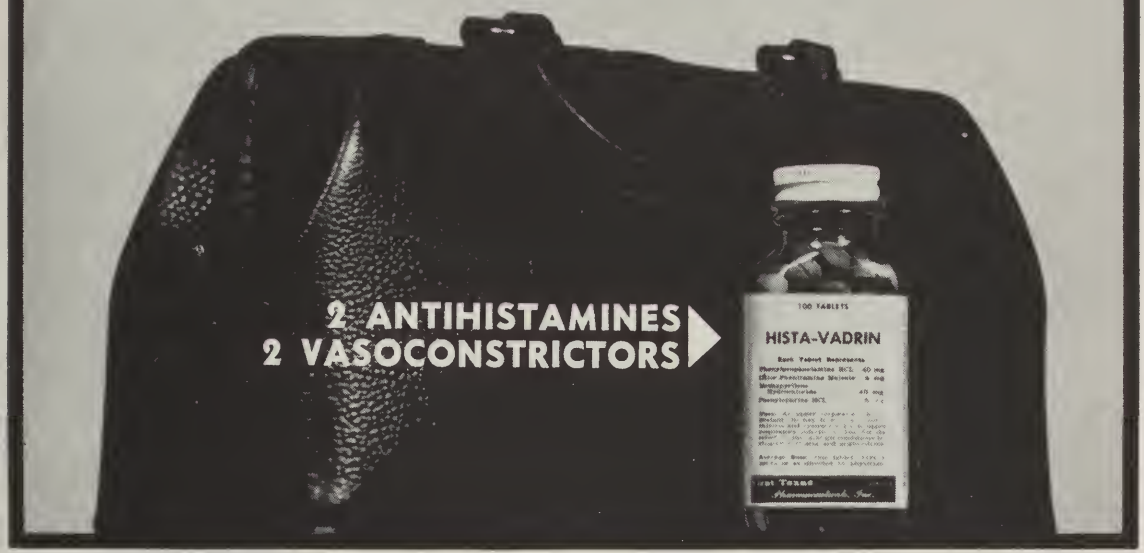
May evidenced parent interest and concern, appreciation and enthusiasm stimulate 100 per cent membership enrollment and the exploitation of the potential powers of the Auxiliary branch of the Medical family and focus the unity and harmony we should exhibit.

Nancy E. Roles, President
Woman's Auxiliary to KSMA

This is the first of a series of four guest articles written at the invitation of Richard G. Elliott, M.D., KSMA president.

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HISTA-VADRIN, an upper respiratory decongestant, is designed for the oral relief of congestion and edema of the upper respiratory passages. The ANTIHISTAMINIC drugs methapyriline and chlor-pheniramine are noted for their ability to prevent vasodilatation and inflammatory edema caused by the release of histamine.

VASOCONSTRICTORS, phenylpropanolamine and phenylephrine oppose mucosal edema by constricting blood vessels which have been dilated by histamine and other factors involved in inflammation. These vasoconstrictors are not as likely to cause excitement or wakefulness as ephedrine or methamphetamine (1).

Indications: For the relief of hay fever, vasomotor rhinitis, and symptoms resulting from upper respiratory infections. Hista-vadrin can afford relief also in other allergic conditions such as urticaria and angioedema.

Each scored Hista-vadrin tablet contains:

Phenylpropanolamine Hydrochloride	40 mg.
Chlor-Pheniramine Maleate	4 mg.
Methapyriline Hydrochloride	40 mg.
Phenylephrine Hydrochloride	5 mg.

Dosage: Adult Dose, 1 tablet every six hours or in accordance with therapeutic response.

Supplied: Slow release scored tablets designed to disintegrate in 2 to 3 hours.

Reference available on request.

Samples and professional literature on request.

HISTA-VADRIN is another "established need" product

in our 61st year . . . **First Texas *Pharmaceuticals, Inc.***

DALLAS, TEXAS • SINCE 1901



THE INSURANCE PAGE



AMA To Assume New Leadership

". . . RESOLVED, that the House of Delegates directs the Board of Trustees and the Council on Medical Service to assume immediate leadership in consolidating the efforts of the American Medical Association with the National Association of Blue Shield Plans, the American Hospital Association and the Blue Cross Association into maximum development of the voluntary non-profit prepayment concept to provide medical care for the American people . . ."

By this resolution, adopted in Washington, November 30, 1960, the AMA served notice of its firm commitment to the voluntary non-profit plans as the primary instrument through which America's free medical profession and its voluntary hospital system hope to meet the challenge of the future in providing medical services.

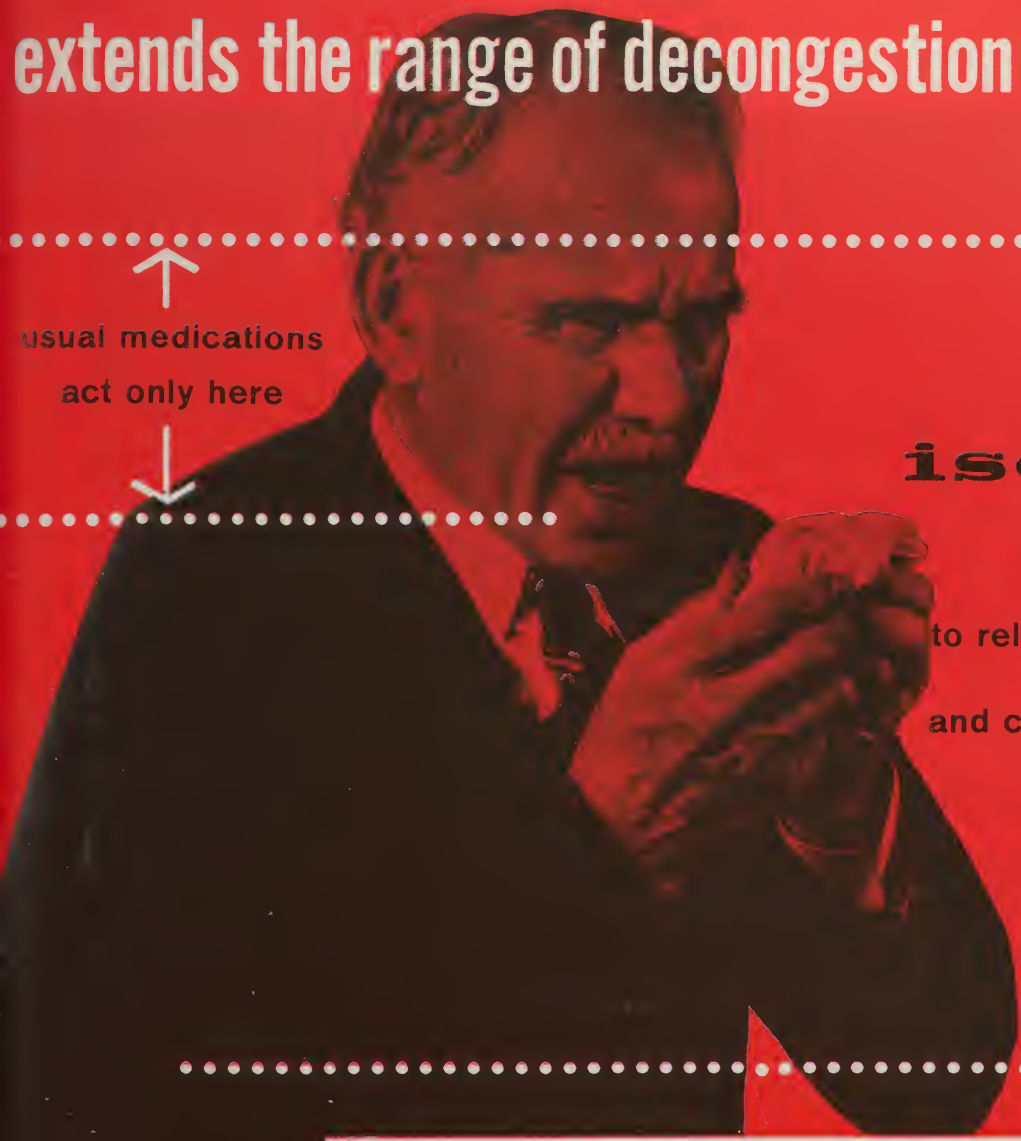
This resolution also placed the AMA in its rightful place of leadership in supporting and guiding the development of Blue Shield. It goes far to assure that organized medicine at the national level will henceforth demonstrate the same direction and support for Blue Shield that the leaders of so many state and county components of AMA have given local Blue Shield Plans from their very inception.

A great opportunity confronts AMA in this new role. By exercising bold and imaginative leadership, AMA may be able to help raise the general level of Blue Shield performance to the point where the "voluntary non-profit prepayment concept" will have proved its case to the American people. Certainly there's much to be done to establish standards for Blue Shield and to bring the performance of all Plans up to the level of the best.

It's none too soon for this leadership to make itself felt!

W. Vinson Pierce, M.D.

extends the range of decongestion in COLDS



usual medications act only here

NEW **isoclor** acts here to relieve both nasal and chest discomfort

NEW

isoclor™

TABLETS AND SYRUP

relieves both / **upper respiratory congestion bronchial congestion**

- **effective** because d-isoephedrine combines both nasal and bronchial decongestant actions[1]—together with the histamine blocking action of chlorpheniramine.
- **fast** . . . clears air passages in 10-20 minutes. Relieves stuffiness, swelling, discharge. Prevents excessive post-nasal drip and resulting night cough.
- **safe** . . . Laboratory studies reveal little effect on CNS or pressor stimulation.[2] Minimal daytime drowsiness or interference with sleep.

1. Aviado, D. M. et al: J. Pharmacol. & Exper. Therap. 122: 406-417 (Mar.) 1958. 2. Laboratory Report: Research Div., Chas. C. Haskell & Co., 1959.

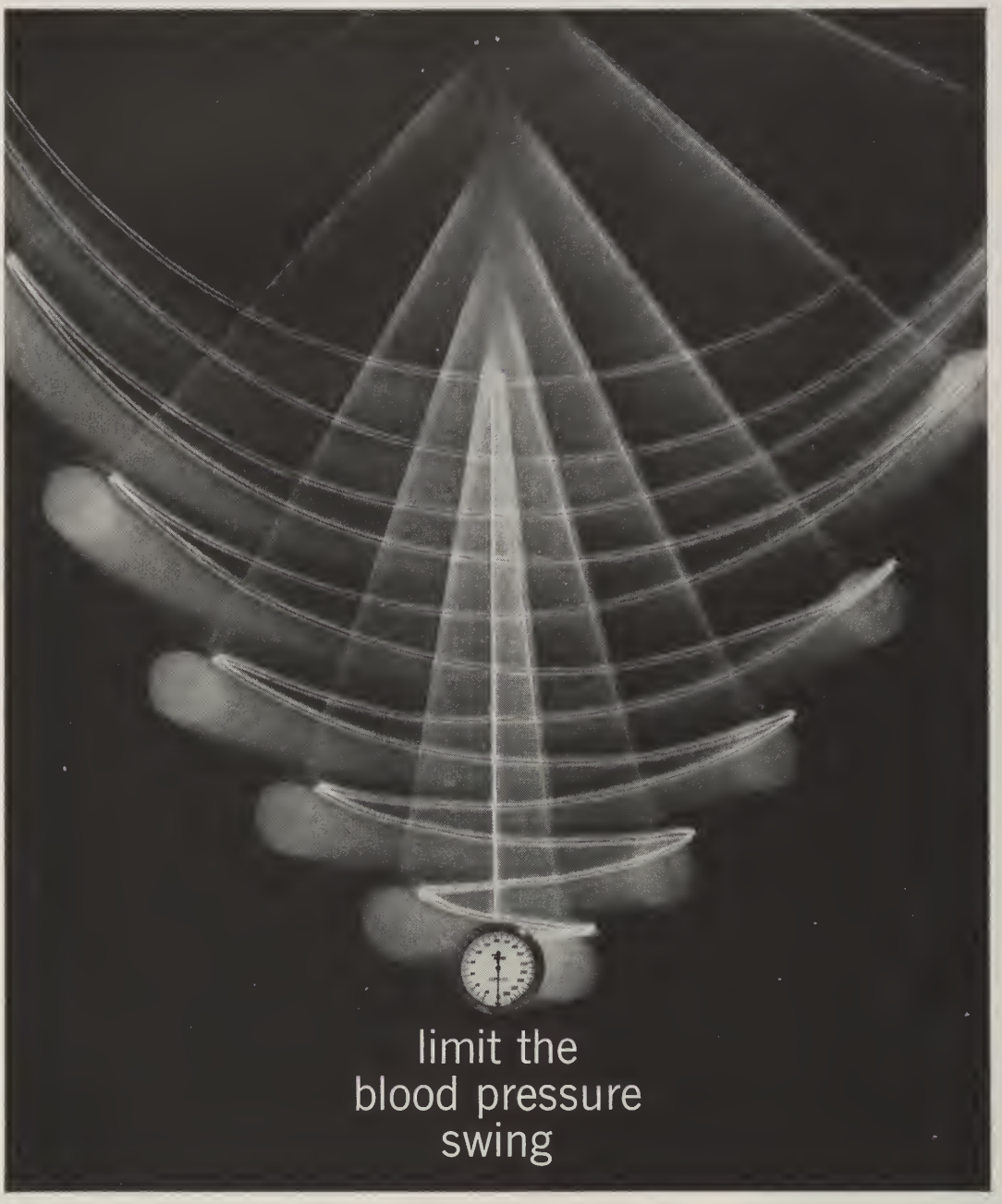
TABLETS AND SYRUP for adults and children . . .

COMPOSITION:	Per tablet	Per 5 ml. syrup
Chlorpheniramine maleate.....	4 mg.	2 mg.
d-Isoephedrine HCl.....	25 mg.	12.5 mg.

DOSE: Tablets: Adults: 1 tablet 3 or 4 times daily. Syrup: Children: 3-6 yrs. ½ tsp. t.i.d.; 6-12 yrs. 1 tsp. t.i.d. Adults: 2 tsp. t.i.d.

AVAILABLE: Tablets: Bottles of 100. Syrup: Pint bottles.

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Rautrax-N lowers high blood pressure gently, gradually . . . protects against sharp fluctuations in the normal pressure swing. Rautrax-N combines Raudixin, the cornerstone of antihypertensive therapy, with Naturetin, the new, safer diuretic-antihypertensive agent. The complementary action of the components permits a lower dose of each thus reducing the incidence of side effects. The result: Maximum effectiveness, minimal dosage, enhanced safety. Rautrax-N also contains potassium chloride — for added protection against possible potassium depletion during maintenance therapy.

Supply: Rautrax-N — capsule-shaped tablets — 50 mg. Raudixin, 4 mg. Naturetin, and 400 mg. potassium chloride. Rautrax-N Modified — capsule-shaped tablets — 50 mg. Raudixin, 2 mg. Naturetin, and 400 mg. potassium chloride. For complete information write Squibb, 745 Fifth Avenue, New York 22, N. Y.

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HAVE NEVER CANCELLED MEMBERSHIP BECAUSE OF AGE OR HEALTH OR WHEN A CHRONIC OR INCURABLE CONDITION DEVELOPED

RECOMMEND AND SUPPORT



BLUE CROSS

Approved by the American Hospital Association

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Sponsored by the Kentucky State Medical Association

REMEMBER:

Blue Cross-Blue Shield continued protection helps older persons:

- Obtain necessary care
- Continue as consumers of goods and services in their communities
- Avoid becoming charity burdens on the community

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BLUE CROSS HOSPITAL PLAN, INC.
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WASHINGTON NEWS DIGEST



Washington, D. C.—Spokesmen for the medical profession at the White House Conference on Aging supported the Kerr-Mills voluntary program for health care of elderly persons as an efficient, economical way to furnish assistance to those who need help.

Leading physician delegates to the conference also continued vigorous opposition to the Social Security approach espoused by organized labor.

Continuing their all-out campaign for the Social Security approach, labor union leaders used the conference as a forum for further attacks on the medical profession.

•

J. Lafe Ludwig, M.D., Los Angeles, chairman of the American Medical Association Council on Medical Service, told a pre-conference meeting of the physician delegates that it would be a "national tragedy—unfair to old and young alike—if the Kerr-Mills law should be shelved for a Social Security plan for medical care of the aged.

"Federal medicine would mean red tape, bureaucratic control, and high costs," Doctor Ludwig said. "Most important of all, it would mean inferior medical care for the people whom we are trying to help."

Describing the Kerr-Mills law as an "historic milestone," Doctor Ludwig said the "overwhelming majority" of the nation's physicians believe it is "an excellent law which can and will work and deserves every opportunity to do so."

•

Leonard W. Larson, M.D., Bismarck, N. D., president-elect of the AMA, told the conference's Health and Medical Care Section that more attention must be given to keeping older persons healthy. He was chairman of the section.

"We spend millions of dollars and hours developing sound, well-based programs for care of the sick, but at the same time we virtually ignore the vast opportunities for preservation and promotion of health," Doctor Larson said.

"We must do more than react to the minority of older persons who are ill—we must act for the great majority who are well."

In a statement issued in Chicago, E. Vincent Askey, M.D., Los Angeles, president of AMA, branded as false an allegation that the White House Conference had been "captured" by organized medicine, private insurance and business interests. Doctor Askey specifically referred to such a charge made by Prof. Wilbur J. Cohen of the University of Michigan, but the AMA president's statement applied to similar charges made by representatives of organized labor.

Doctor Askey implied that, "if anyone has a legitimate complaint regarding the choice of personnel directing the activities" of the key section on income maintenance, it was opponents of the Social Security approach.

•

Doctor Ludwig also answered organized labor's attacks on the AMA at the conference. He accused George Meany, president of the AFL-CIO, of "attempting to undermine" the conference to "further his own partisan interests."

"Meany obviously is prepared to go to any extreme to impugn the motives of those who disagree with him," Doctor Ludwig said. "Delegates to this conference representing medicine and many other groups came here in a spirit of cooperation determined to take realistic action to help the elder citizens of this country.

"Meany, through his campaign of smear and hostility, is making this dificult, if not impossible."

Doctor Ludwig said that some labor leaders "obviously are more interested in saddling the people of this country with a system of socialized medicine" than he is in "helping those older people who really need help."

"Meany and such of his cohorts as Sen. Pat McNamara (D., Mich.) appear to be doing their utmost to create so much confusion that recommendations of the State Conference on Aging will be forgotten," Doctor Ludwig said.

"Of the 30 states making specific recommendations regarding financing of medical care for the aged, only 10 favored the Social Security tax."

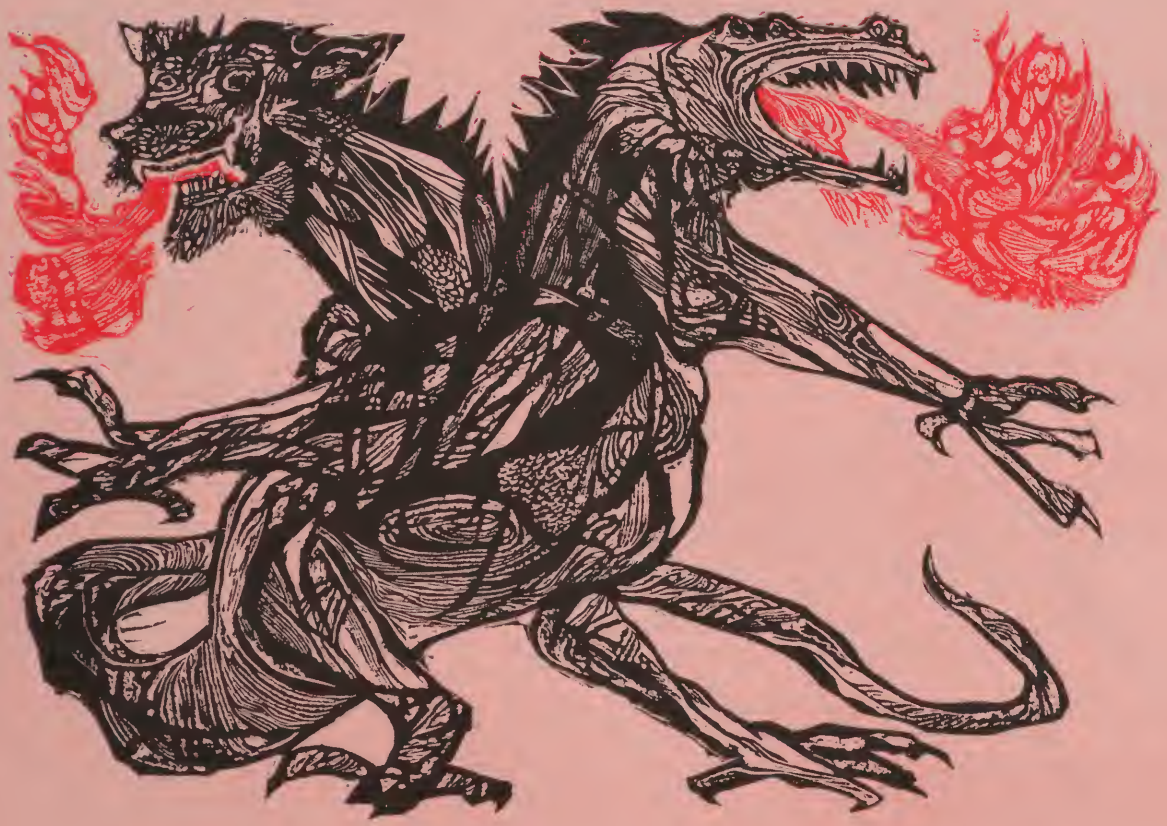
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President Eisenhower urged the 2,700 delegates to the conference to reconcile their differing views and agree on a sound program. He told the delegates it was their responsibility to provide "some kind of guidance for Congress to use in its future deliberations."

President John F. Kennedy declined an invitation to address the conference as President-elect. He and Congressional Democratic leaders decided weeks before the conference to make medical care for the

(Continued on Page 190)

When severe pain accompanies skeletal muscle spasm ease both 'pain & spasm'



with **Robaxisal**®

ROBAXIN® with Aspirin

A dual-acting skeletal muscle relaxant-analgesic, combining the clinically proven relaxant action of ROBAXIN with the time-tested pain relieving action of aspirin.

Each **ROBAXISAL** Tablet contains:
ROBAXIN (methocarbamol Robins) 400 mg. Acetylsalicylic acid (5 gr.)..... 325 mg.
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Or ROBAXISAL®-PH (ROBAXIN with Phenaphen®) — when anxiety is associated with painful skeletal muscle spasm.

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Phenacetin 97 mg. Hyoscyamine sulfate 0.016 mg. Phenobarbital (1/8 gr.) 8.1 mg.
Supply: Bottles of 100 and 500 green-and-white laminated tablets.

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Complete Cholesterol Depressant Menus and Recipe Book

A new, authoritative patient-aid . . . for professional distribution only

Now available for use in your practice from The Wesson People . . . easy-to-use manual of 40 pages, including all necessary diet instructions . . . menus, recipes, shopping and cooking guidance . . . all worked out for you . . . so arranged and printed that you have only to check the desired daily calorie level before giving the book to your patient.

You will find this book invaluable for treating patients with elevated serum cholesterol.

Complete menus for 10 days enable you to prescribe diets which are appetizing, nutritiously adequate and which can exert cholesterol depressant activity. Special attention has been given to constructing the menu patterns so that they adhere as closely as permissible to the patient's normal eating habits.

NRC Standards fulfilled. Each menu has been calculated to provide the proper daily allowance of proteins, vitamins and other nutrients as recommended by the Food and Nutrition Board of the National Research Council.

Weight control is achieved as each day's menu is given at 3 calorie levels—1200, 1800 and 2600 calories. You prescribe the level most desirable and modify as desired.

Variety and appetite appeal for patient are built into the menu plan to an extent not previously accomplished. Alternate choices for main dishes minimize monotony, encourage the patient to follow closely the menu plan you specify.

Complete recipes—65 in all—are included to assure that the specified menus provide prescribed levels of calories, the pre-determined ratio of poly-unsaturated to saturated fat, plus essential nutrients.

Dietary fat is controlled so that approximately 36% of the total calories are derived from fat and at least 40% of these fat calories are from poly-unsaturated components (linoleates) as found in pure vegetable oil. The replacement of saturated dietary fat by this percentage of poly-unsaturated fat has been found in clinical studies most effective in the reduction of serum cholesterol and in its maintenance at desirable levels. More liberal menus are provided for maintenance after the patient's progress indicates that desired therapeutic results have been accomplished.

Family meal preparation is simplified. The menus are planned around favorite foods having wide appetite appeal for all members of the household. Patients can entertain in comfort—enjoy cakes, cookies, snacks, prepared with recipes which meet medical requirements.

A high degree of satiety is achieved even at the lower calorie levels, because Wesson provides an unexcelled source of concentrated, slow-burning food energy.

Adaptable for use with diabetics. Carbohydrates have been calculated to fall within the acceptable range for patients to whom a diet planned for diabetes is important. Calories, which must be supplied from fat when the carbohydrate intake is limited, are provided by desirable poly-unsaturated vegetable oil.

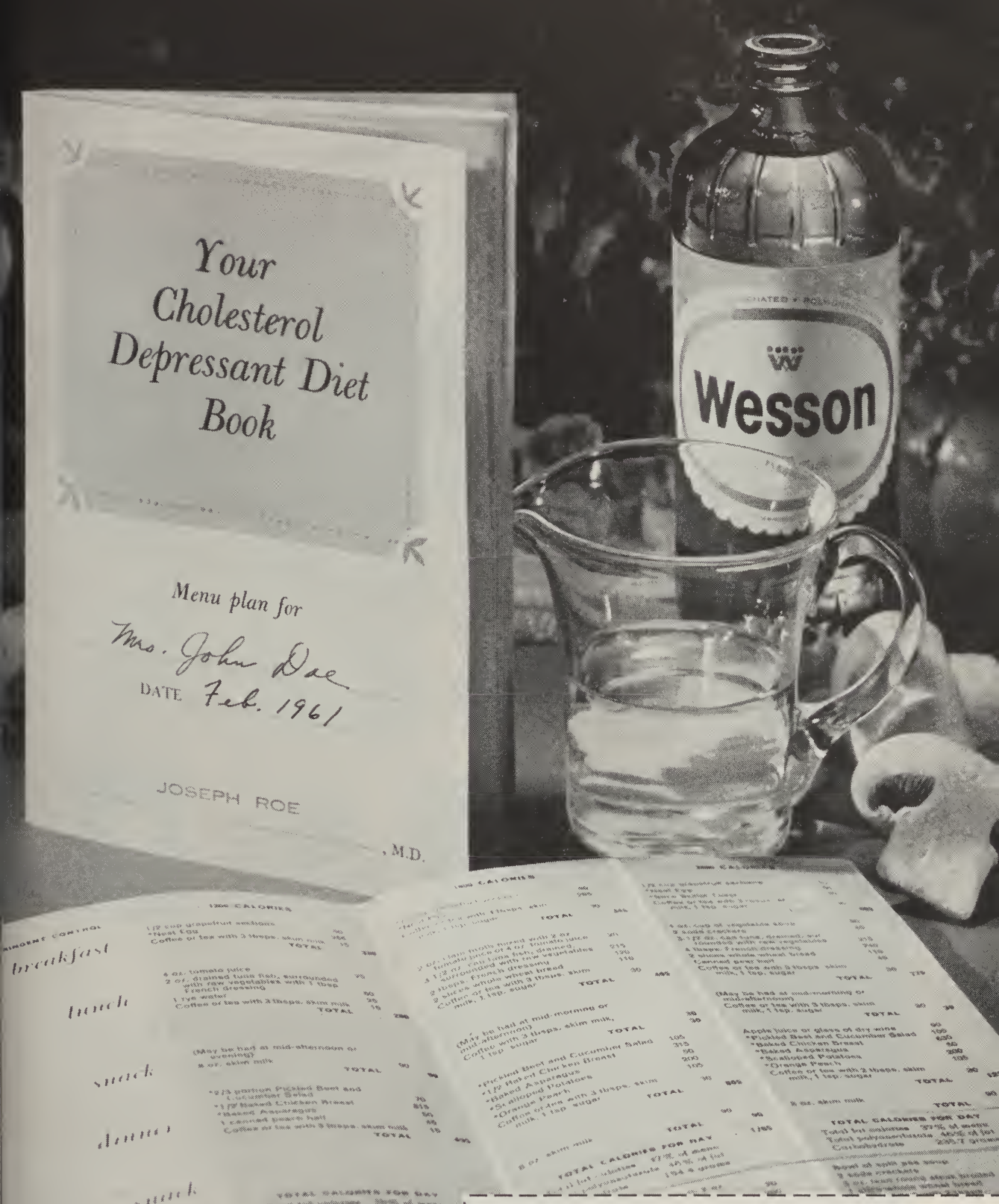
WESSON'S IMPORTANT CONSTITUENTS

Wesson is 100% cottonseed oil—winterized and of selected quality

Linoleic acid glycerides (poly-unsaturated)	50-55%
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Total unsaturated	70-75%
Palmitic, stearic and myristic glycerides (saturated)	25-30%
Phytosterol (Predominantly beta sitosterol)	0.3-0.5%
Total tocopherols	0.09-0.12%

Never hydrogenated—completely salt free

Poly-unsaturated Wesson is unsurpassed by any readily available brand, where a vegetable (salad) oil is medically recommended for a cholesterol depressant regimen.



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Please send_____free copies of
"Your Cholesterol Depressant Diet Cook Book" for use with patients.

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FOUNDED IN 1904

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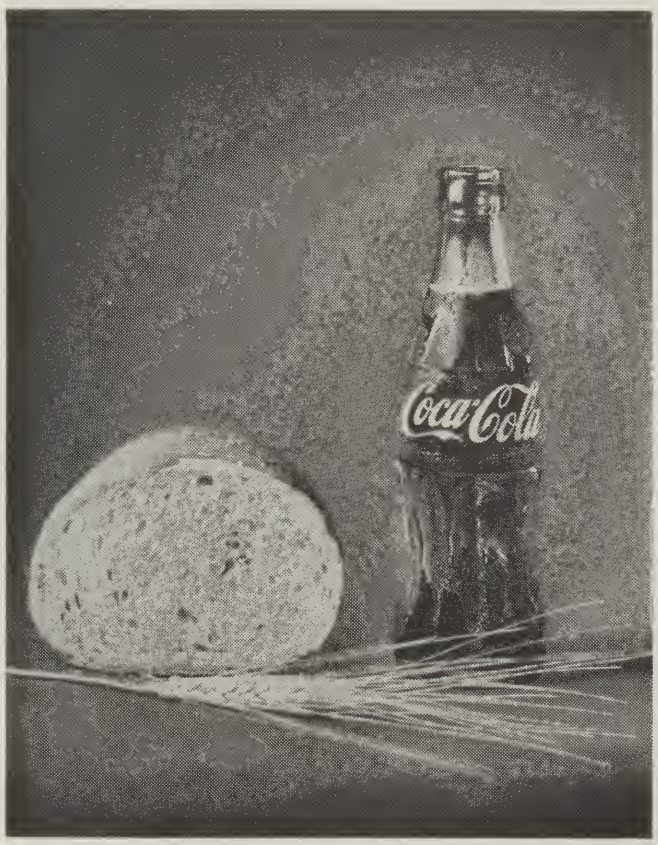


A non-profit psychiatric institution, offering modern diagnostic and treatment procedures—insulin, electroshock, psychotherapy, occupational and recreational therapy—for nervous and mental disorders. The Hospital is located in a 75-acre tract, amid the scenic beauties of the Smoky Mountain Range of Western North Carolina, affording exceptional opportunity for physical and emotional rehabilitation. The OUT-PATIENT CLINIC offers diagnostic services and therapeutic treatment for selected cases desiring non-resident care.

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Coca-Cola, too, has its place in a well balanced diet. As a pure, wholesome drink, it provides a bit of quick energy.. brings you back refreshed after work or play. It contributes to good health by providing a pleasurable moment's pause from the pace of a busy day.

DRINK
Coca-Cola
TRADE-MARK ®

Each of the babies pictured on this page was borne by a mother with a *documented* previous history of true habitual abortion, who was treated with DELALUTIN during the pregnancy leading to this birth

LIVING PROOF OF FETAL SALVAGE WITH

DELALUTIN

SQUIBB HYDROXYPROGESTERONE CAPROATE

Improved Progestational Therapy



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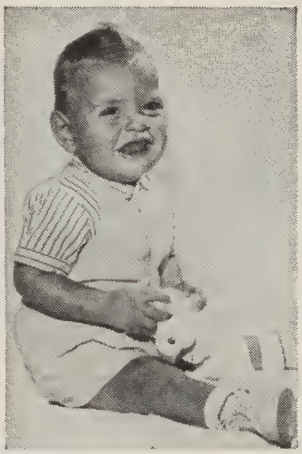
Skokie, Ill.



Denver, Colo.



Denver, Colo.



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DELALUTIN offers these advantages over other progestational agents

• long-acting sustained therapy • more effective in producing and maintaining a completely matured secretory endometrium • no androgenic effect • more concentrated solution requiring injection of less vehicle • unusually well-tolerated, even in large doses • fewer injections required • low viscosity makes administration easy

WHERE HAPPINESS IS SKILLFULLY ADMINISTERED

In Addition To Suitable Medical and Nursing Care for Chronic, Convalescent and Geriatric Patients

NEW CASTLE SANITARIUM

TELEPHONE 3621
NEW CASTLE, KY.

MEMBER:
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Active medical staff of six physicians. Physicians available at all hours. 24 hour efficient and cheerful nursing care WITH SPECIAL EMPHASIS ON MAKING EACH PATIENT FEEL LOVED, WANTED AND IMPORTANT.

Special diets prepared and tray service to all rooms at no extra charge.

Diversional activities, physio-therapy treatments, rehabilitation program and emergency facilities available.

Adequate shade trees, ramps, also day room with abundance of flowers, television.

PRIVATE, SEMI-PRIVATE AND WARD ACCOMMODATIONS AVAILABLE. Private and semi-private rooms with intercommunication, beautifully decorated and furnished, beds equipped with Trendelenburg springs and innerspring mattresses.

Insulated brick and block structure, heated in winter by "Selectemp" Modulated Steam Heat with filtered air for maximum comfort and safety (each room having thermostatic even-heat control with its own circulating air unit).

Protected throughout with automatic fire detection and alarm system.

Cares for men or women, nursing or boarding care cases, bedridden or ambulatory. Admits some mildly senile, nervous and neurotic patients but accepts no alcoholics or drug addiction cases.

REASONABLE RATES

IRA O. WALLACE, Administrator

MARGARET KELLY, R. N., Director of Nurses

Naturally, the most

Complete Optical Service in Kentucky—

Includes:

Contact Lens
service on
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and Artificial Eye service

HOME OWNED SINCE 1897

SOUTHERN OPTICAL
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FRANCIS BLDG.
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ANNOUNCING—
SPECIFICALLY FOR
INFECTIONS DUE TO
"RESISTANT" STAPHYLOCOCCI

AN ENTIRELY NEW SYNTHETIC
"STAPH-CIDAL" PENICILLIN

Staphcillin™

sodium dimethoxyphenyl penicillin
FOR INJECTION

UNIQUE—BECAUSE IT
RETAINS ANTIBACTERIAL
ACTIVITY IN THE PRESENCE OF
STAPHYLOCOCCAL PENICILLINASES
WHICH INACTIVATE
OTHER PENICILLINS

Bristol™

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NEW SYNTHETIC PENICILLIN FOR "RESISTANT" STAPH

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OFFICIAL PACKAGE CIRCULAR
November, 1960

STAPHCILLIN™

(sodium dimethoxyphenyl penicillin)
For Injection

DESCRIPTION

STAPHCILLIN is a unique new synthetic parenteral penicillin produced by Bristol Laboratories for the specific treatment of staphylococcal infections due to resistant organisms. Its uniqueness resides in its property of resisting inactivation by staphylococcal penicillinase. It is active against strains of staphylococci which are resistant to other penicillins.

Each dry filled vial contains: 1 Gm. STAPHCILLIN (sodium dimethoxyphenyl penicillin), equivalent to 900 mg. dimethoxyphenyl penicillin activity.

INDICATIONS

STAPHCILLIN is recommended as specific therapy only in infections due to strains of staphylococci resistant to other penicillins, e.g.:

Skin and soft tissue infections: cellulitis, wound infections, carbuncles, pyoderma, furunculosis, lymphangitis and lymphadenitis.

Respiratory infections: staphylococcal lobar or bronchopneumonia, and lung abscesses combined with indicated surgical treatment.

Other infections: staphylococcal septicemia, bacteremia, acute or subacute endocarditis, acute osteomyelitis and enterocolitis.

Infections due to penicillin-sensitive staphylococci, streptococci, pneumococci and gonococci should be treated with Syncillin® or parenteral penicillin G rather than STAPHCILLIN. Treponemal infections should be treated with parenteral penicillin G.

DOSAGE AND ADMINISTRATION

STAPHCILLIN is well tolerated when given by deep intragluteal or intravenous injection.

As is the case with other antibiotics, the duration of therapy should be determined by the clinical and bacteriological response of the patient. Therapy should be continued for at least 48 hours after the patient has become afebrile, asymptomatic and cultures are negative. The usual duration has been 5-7 days.

Intramuscular route: The usual adult dose is 1 Gm. every 4 or 6 hours. Infants' and children's dosage is 25 mg. per Kg. (approximately 12 mg. per pound) every 6 hours.

Intravenous route: 1 Gm. every 6 hours using 50 ml. of sterile saline solution at the rate of 10 ml. per minute.

**Warning:* Solutions of STAPHCILLIN and kanamycin should not be mixed, as they rapidly inactivate each other. Data on the results of mixing STAPHCILLIN with other antibiotics are being accumulated.

DIRECTIONS FOR RECONSTITUTION

Add 1.5 ml. sterile distilled water or normal saline to a 1 Gm. vial and shake vigorously. Withdraw the clear, reconstituted solution (2.0 ml.) into a syringe and inject. The reconstituted solution contains 500 mg. of STAPHCILLIN per ml. Reconstituted solutions are stable for 24 hours under refrigeration.

For intravenous use, dilute the reconstituted dose in 50 ml. of sterile saline and inject at the rate of 10 ml. per minute.

*This statement supersedes that in the Official Package Circulars dated September and/or October, 1960.

(continued)

MICROBIOLOGICAL AND PHARMACOLOGICAL PROPERTIES

In vitro studies show that STAPHCILLIN is a bactericidal penicillin with activity against staphylococci resistant to penicillin G. Strains of staphylococci so far tested have been sensitive to STAPHCILLIN *in vitro* at concentrations of 1-6 mcg. per ml. These levels are readily attained in the blood and tissues by administration of STAPHCILLIN at the recommended dosage. This unique attribute is probably due to the fact that STAPHCILLIN is stable in the presence of staphylococcal penicillinase. STAPHCILLIN also resists degradation by *B. cereus* penicillinase. The antimicrobial spectrum of STAPHCILLIN with regard to other microorganisms is qualitatively similar to that of penicillin G; but considerably higher concentrations of STAPHCILLIN are required for bactericidal activity than is the case with penicillin G.

STAPHCILLIN is rapidly absorbed after intramuscular injection. Peak blood levels (6-10 mcg./ml. on the average after a 1.0 Gm. dose) are attained within 1 hour; and then progressively decline to less than 1 mcg. over a 4 to 6 hour period. It is poorly absorbed from the gastrointestinal tract. STAPHCILLIN is rapidly excreted by the kidney.

As shown by animal studies, STAPHCILLIN is readily distributed in body tissues after intramuscular injection. Of the tissues studied, highest concentrations are reached in the kidney, liver, heart and lung in that order; the spleen and muscles show lower concentrations of the antibiotic. STAPHCILLIN diffuses into human pleural and prostatic fluids, but its diffusion into the spinal fluid has not yet been completely studied. However, one patient with meningitis showed a significant concentration in his spinal fluid while on STAPHCILLIN therapy.

Toxicity studies with STAPHCILLIN and penicillin G in animals show that they have approximately the same low order of toxicity.

Certain staphylococci can be made resistant to STAPHCILLIN in the laboratory, but this resistance is not related to their penicillinase production. During the clinical trials, no STAPHCILLIN-resistant strains of staphylococci were observed or developed; the possibility of the emergence of such strains in the clinical setting awaits further observation.

PRECAUTIONS

During the clinical trials, several mild skin reactions, e.g., itching, papular eruption and erythema were observed both during and after discontinuance of STAPHCILLIN therapy. Patients with histories of hay fever, asthma, urticaria and previous sensitivity to penicillin are more likely to react adversely to the penicillins. It is important that the possibility of penicillin anaphylaxis be kept in mind. Epinephrine and the usual adjuvants (antihistamines, corticosteroids) should be available for emergency treatment. Because of the resistance of STAPHCILLIN to destruction by penicillinase, parenteral *B. cereus* penicillinase may not be effective for the treatment of allergic reactions. Information with regard to cross-allergenicity between penicillin G, penicillin V, phenethicillin (Syncillin) and STAPHCILLIN is not available at present. If superinfection due to Gram-negative organisms or fungi occurs during STAPHCILLIN therapy, appropriate measures should be taken.

SUPPLY

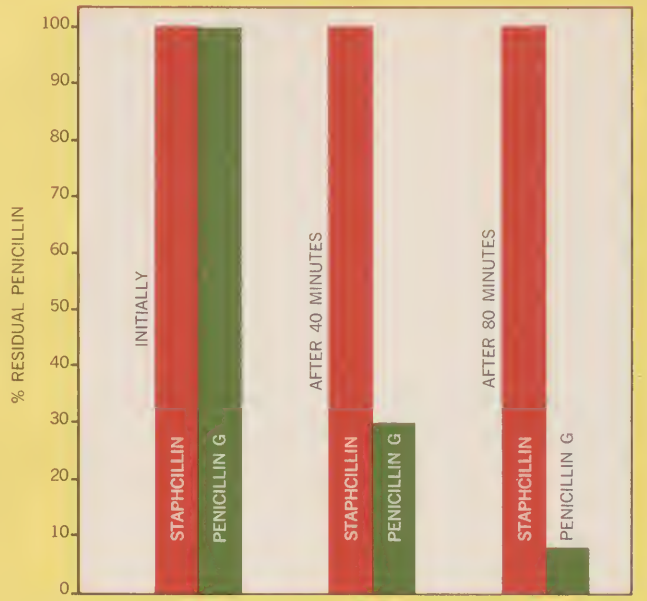
List 79502 — 1.0 Gm. dry filled vial.

BRISTOL LABORATORIES · SYRACUSE, NEW YORK
Division of Bristol-Myers Company

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UNIQUE SYNTHETIC "STAPH-CIDAL" PENICILLIN

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In the presence of staphylococcal penicillinase, STAPHCILLIN remained active and retained its antibacterial action. By contrast, penicillin G was rapidly destroyed in the same period of time. *(After Gourevitch et al., to be published)*

Specifically for "resistant" staph...

Staphcillin™

sodium dimethoxyphenyl penicillin
FOR INJECTION

The failure of staphylococcal infections to respond to penicillin therapy is attributed to the penicillin-destroying enzyme, penicillinase, produced by the invading staphylococcus.

Unlike other penicillins:

1 STAPHCILLIN is effective because it retains its antibacterial activity despite the presence of staphylococcal penicillinase.

2 The clinical effectiveness of STAPHCILLIN has been confirmed by dramatic results in a wide variety of infections due to "resistant" staphylococci, many of which were serious and life-threatening.

Like other penicillins:

STAPHCILLIN has no significant systemic toxicity. It is well tolerated locally, and pain or irritation at the injection site is comparable to that following the injection of penicillin G. *In occasional cases, typical penicillin reactions may be experienced.*

PROFESSIONAL INFORMATION SERVICE — The attached Official Package Circular provides complete information on the indications, dosage, and precautions for the use of STAPHCILLIN. If you desire additional information concerning clinical experiences with STAPHCILLIN, the Medical Department of Bristol Laboratories is at your service. You may direct your inquiries via collect telephone call to New York, PLaza 7-7061, or by mail to Medical Department, Bristol Laboratories, 630 Fifth Ave., N. Y. 20, N. Y.

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Division of Bristol-Myers Company

EFFECTIVE ANTIHISTAMINE-DECONGESTANT ACTION



COVANAMINE'S combination of two antihistamines and two decongestants—shrinks swollen turbinates—opens blocked ostia—promotes drainage—reestablishes patency—in the treatment of common colds, rhinitis, sinusitis, nasal allergies and post nasal drip.

Constant therapeutic levels are maintained by COVANAMINE'S Sustained Action Tablets which meter out the active ingredients . . . with minimal side effects, less drowsiness.

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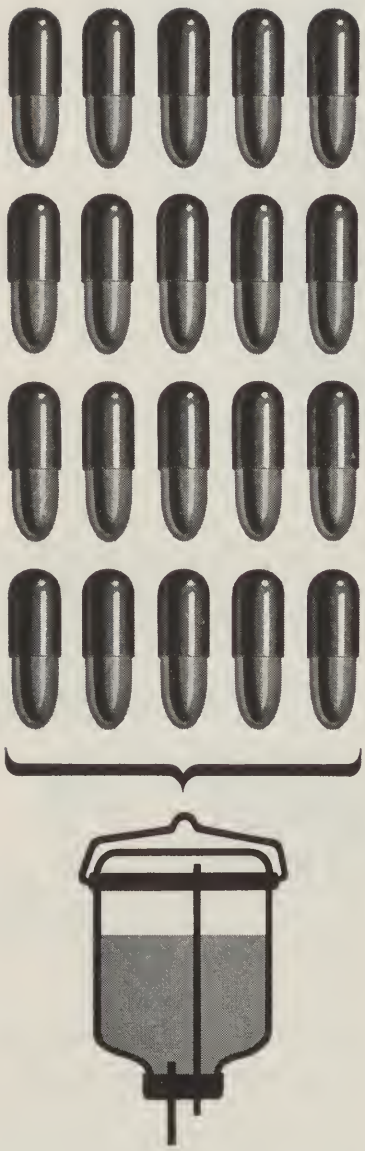
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Steering Wheel Blunt Abdominal Trauma*

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Louisville, Ky.

Intra-abdominal injuries due to blunt abdominal trauma are discussed and three cases presented. A plea is made for employing abdominal paracentesis in these difficult diagnostic cases

THE purpose of this paper is to emphasize the serious nature of intra-abdominal injuries due to blunt abdominal trauma in automobile accidents, to re-emphasize the proven, but sometimes forgotten value of abdominal paracentesis as a valuable diagnostic procedure in these cases, and to present three illustrative cases.

In 1958 there were 37,000 deaths due to automobile accidents in the nation.[1] There were 789 automobile deaths in Kentucky during that year[2].

In a study of 724 consecutive cases of traffic injuries, R. W. Zollinger found that injury to the head occurred in 40 per cent of the cases, and resulted in 19 of the 28 deaths. In his series abdominal injuries were rare, but there was a high fatality rate among these cases. He reported four cases of abdominal injuries in his total series of 724 cases. Three of these four patients died.[27]

Case Reports

1. Mr. J. S.—Case Number 83269

Present Illness: A 25-year-old white male farmer was admitted to the Louisville V. A. Hospital on March 9, 1956, with the chief complaint of colicky pain in the lower abdomen. The patient had been in an automobile accident in October of 1955, and had been hospitalized for six days at Berea, Ky. No reliable history of abdominal or chest trauma could be elicited from the patient because he had been drinking prior to the accident; however, following the accident he remembered having colicky right and left lower quadrant abdominal pain followed by hematemesis. Approximately one month after discharge from the Berea Hospital, he had a second bout of colicky lower abdominal pain, and was hospitalized at Richmond, Ky. Chest X-rays during this admission showed the stomach and part of the intestines in the left thorax. Prior to his admission to the Louisville V. A. Hospital, he had several other bouts of similar pain associated with nausea and vomiting. He had lost approximately 20 pounds since the automobile accident. Since the automobile accident the patient had experienced mild exertional dyspnea, but no chest pain.

*From the Department of Surgery, University of Louisville School of Medicine, the Louisville Veterans Administration Hospital and the Jewish Hospital, Louisville, Kentucky. Published with permission of the Chief Medical Director, Department of Medicine and Surgery, Veterans Administration, who assumes no responsibility for opinions expressed or conclusions drawn by the author.

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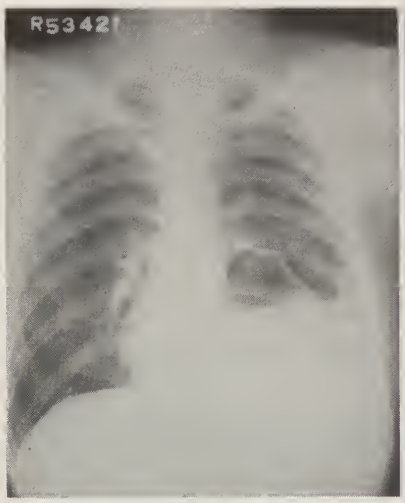


Figure 1



Figure 2



Figure 3

Figures 1, 2 and 3—Case J. S., P-A Chest x-ray demonstrating distended stomach and small intestine in left hemithorax; lateral chest x-ray demonstrating the same findings; upper gastrointestinal series demonstrating stomach and small intestine in left hemithorax.

The system review and past history were otherwise non-contributory to the present illness.

Physical Examination revealed a fairly well-developed, fairly well-nourished white male appearing chronically but not acutely ill. There were diminished breath sounds in the left lower lobe region posteriorly and laterally with hyperactive peristaltic sounds in this same region. A few rales were also noted in this same area. The abdomen was scaphoid. There was no abdominal tenderness. The remainder of the physical examination was within normal limits.

Laboratory Studies: Chest X-rays on March 13, 1956 showed herniation of both large and small bowel and stomach through the left diaphragm into the left thorax. The stomach contained a large air fluid level and was considerably distended. There were mutliple air fluid levels in the small bowel. The mediastinum was shifted to the right. Upper GI series obtained on March 9, 1956 confirmed the presence of the stomach and small intestines in the left thorax. C. B. C. and urinalysis were within normal limits. E. K. G. was normal.

Progress in Hospital: Under general endotracheal anesthesia left thoracotomy through the bed of the eighth rib was performed on March 14, 1956. All of the ileum and jejunum, omentum, transverse colon, the entire stomach, and the tip of the left lobe of the liver were in the left hemithorax. Many adhesions in the posterior and lateral aspect of the thorax were cut. The stomach, transverse colon, small intestine, omentum, and the left lobe of the liver were replaced into the abdominal cavity and a 6x3x2 inch diaphragmatic defect was closed by imbricating the posterior leaf over the anterior leaf using 00 cotton interrupted sutures. A second line of closure of cotton sutures was employed. The left lung was completely re-expanded; a number 26 thoracotomy tube was placed in the left pleural space and brought out through a stab wound in the ninth intercostal space. The chest was closed in layers with interrupted cotton sutures. The patient returned to the ward in good condition. There was minimal loss of blood. No blood transfusions were given. The patient made a good recovery. After returning from hospital leave a repeat upper GI series on the 41st postoperative day was obtained; it revealed a hypotonic stomach but was otherwise normal. The left leaf of the diaphragm had limited excursions but no paradoxical motion. The patient was discharged in good condition.

2. Mr. W. H. W.—Case No. 92456

Present Illness: This 44-year-old white male was driving his automoblie on October 23, 1957 at about midnight when he suddenly lost consciousness. Some time later he awoke and

found that he had struck a telephone pole. He noted some soreness over the right side of his chest. He was taken home and awoke in the morning with severe right abdominal pain which was most severe in the right lower quadrant. He also had pain over the right anterior chest. By the time he was admitted to the Louisville V. A. Hospital at 7:15 p.m. on October 24, 1957, he had vomited several times. The patient denied hematemesis. There was no radiation of the pain into the back. The patient's past history was essentially negative except for the following: he had a right Bell's palsy approximately three months ago, and a left Bell's palsy approximately 14 months ago. He had been a moderate consumer of alcohol. The patient had had a left nephrectomy in 1945 for left nephrolithiasis.

Physical Examination: Revealed a temperature of 100.4, pulse 90, respiration 26, blood pressure 160/100. The general appearance was that of a 44-year-old white male who was well developed, well nourished, somewhat lethargic and in acute distress with bilateral facial paresis. He had an alcoholic odor to his breath and his oral mucous membranes were dry. His chest, lungs, and heart findings were normal. Abdominal examination revealed board-like rigidity of the entire abdomen. No peristalsis was heard. There was three plus tenderness in the right upper, left upper, and left lower quadrants with four plus tenderness in the right lower quadrant. There was two plus rebound tenderness in the left upper, and three plus rebound tenderness in the left lower quadrants both referred to the right lower quadrant. There was also three plus rebound tenderness in the right upper and the right lower quadrants. On rectal examination there was tenderness high on the right; no other anorectal pathology was detected. Examination of the back revealed no vertebral or CVA tenderness. The remainder of the physical examination was essentially negative. Gastric aspiration was negative for blood. Right lower quadrant abdominal paracentesis yielded 10 cc of dark brown fluid with a serum amylase concentration of 1600 amylase units.

Laboratory Studies: Urinalysis was essentially negative. WBC was 19,800 with a hemoglobin of 17.8 gm. per cent and hematocrit of 49 per cent. Chest x-ray showed subsegmental atelectasis in the right lower lung field, with an area of ill-defined radiolucency beneath the right leaf of the diaphragm. X-ray films of the abdomen on admission revealed a single gas-filled loop of small bowel in the mid-abdomen and radiolucencies beneath the right leaf of the diaphragm. The serum amylase on admission was 705 amylase units.

Progress in Hospital: On the evening of October 24, 1957, an exploratory laparotomy was performed after adequate pre-operative preparation. General endotracheal anesthesia was employed. The abdomen was opened with a transverse upper abdominal incision. The operative findings were as follows: a transverse laceration of the second portion of the duodenum, one inch below the level of the ampulla of Vater was found. The laceration extended approximately 5/8 of the circumference of the duodenum. The intact 3/8 of the duodenum was on the medial aspect. There was an associated traumatic pancreatitis of the head of the pancreas with fat necrosis and a marked amount of retroperitoneal edema with staining of the retroperitoneal fatty tissue with bile. There was approximately one liter of dark amber intraperitoneal fluid containing necrotic fat particles. No other intra-abdominal pathology was detected. A Kocher maneuver was carried out. The intraperitoneal fluid was aspirated and culture of this fluid was obtained. The duodenal laceration was closed transversely with two rows of interrupted cotton sutures, and an incision was made in the posterior parietal peritoneum just lateral to the duodenal loop. A minimal amount of fluid exuded from the retroperitoneal space. Three Penrose drains were brought out through a stab wound to the right of the primary incision, one draining the omental bursa, one draining the retroperitoneal space and the third near the site of the duodenorrhaphy. One million units of aqueous penicillin and one gram of streptomycin were instilled into the peritoneal space before closing the abdomen with through and through interrupted stainless steel sutures.

Post-operatively the patient had a very stormy course despite intensive supportive therapy including nasogastric suction, in-

travenous fluids, electrolytes, vitamin K1, penicillin, streptomycin, and Demerol.® Increasing atelectasis and bilateral bronchopneumonia necessitated two bronchoscopies on the fourth and fifth post-operative days. The patient developed impending delirium tremens on the fourth post-operative day at which time a small pelvic abcess was also detected. The abscess resolved without surgical drainage. The patient's urinary output was good throughout, but electrolyte balance was difficult to control because of the profuse discharge from around the Penrose drains. After the first seven post-operative days the patient showed major improvement, but he continued to run a low grade fever until the abdominal wound was probed on the 25th post-operative day and 50 cc of pus was obtained. Culture yielded a growth of A. aerogenes and hemolytic staphylococcus aureus. Subsequently the patient rapidly improved and was discharged. The finding of dark brown fluid by abdominal paracentesis expedited celiotomy.



Figure 4

Case. M. L. G., I. V. P. demonstrating extravasation of contrast media from left kidney and left perinephric soft tissue mass which was a hematoma.

3. Mrs. M. L. G., Case No. 5061, Jewish Hospital

Present Illness: This 30-year-old white female was admitted to the Jewish Hospital, Louisville, Kentucky, on October 12, 1958. The patient had been in an automobile accident at 8:30 p.m. on this date, and she found herself pinned between her husband, who had been driving, and the steering wheel. She incurred trauma to the left lumbar portion of the back and the upper part of her abdomen. The patient vomited one time in the emergency room. There was no hematemesis. She denied cervical and shoulder radiation of her abdominal pain. Catheterization was positive for gross hematuria. Her past history was non-contributory.

Physical Examination: Revealed a temperature of 99.6, pulse 64, respiration 18, blood pressure 112/80. She was well developed, well nourished, mentally alert, and did not appear acutely nor chronically ill. Chest examination revealed generalized tenderness of the left lower posterolateral chest region. The remainder of chest, heart, and lung examination was negative. Abdominal examination revealed one plus tenderness in the right upper, three plus tenderness in the left upper, and two plus tenderness in the left lower quadrants, with no tenderness in the right lower quadrant. There was two plus rebound tenderness in the left upper, and one plus rebound tenderness in the right lower quadrants. The remainder of the abdominal examination was normal. There was two plus left CVA tenderness. Rectal examination was negative.

Laboratory Examinations: Hemoglobin 12.2 gm. per cent with hematocrit 40 per cent. Urinalysis: cloudy red appearance; specific gravity 1.002; ph: 6.5; albumin 1+; microscopic: many RBC's. The remainder was essentially negative. Serum amylase was eight units. (The normal at this hospital being 20 to 40 units). Flat and upright, and left lateral decubitus x-ray films of the abdomen on the night of admission failed to reveal definite evidence of free intraperitoneal air. There was a suggestion of a mass-like area in the left kidney region. The chest x-ray was negative. IVP done on 10-14-58, showed a mass-like lesion surrounding the left kidney. There was an irregular collection of contrast media in and around the left kidney. The remainder of the IVP findings were normal.

Progress in Hospital: On the night of admission the patient frequently vomited small amounts of clear gastric juice. Abdominal paracentesis to the left of the umbilicus yielded a dry tap. On the following morning the urine had become clearer; peristalsis was present, but not active. There was rebound tenderness at this time in the right upper, and right lower quadrants of the abdomen, and the rebound tenderness in the left upper quadrant had increased in degree, however, there was less left CVA tenderness. The vomiting persisted; peristalsis became less active. The urine again became bloody, and a nasogastric Levine tube was inserted, and gastric suction was employed. A few small blood clots were aspirated from the stomach. A mass became palpable in the left upper abdominal quadrant, and the hemoglobin dropped to 11.5 gm. per cent and the hematocrit to 33 per cent. Exploratory laparotomy was performed on 10-14-58, through an upper abdominal transverse incision.

Operative Findings

The operative findings were as follows: there was a small hematoma over the anterior surface of the stomach along the lesser curvature. The spleen showed several subcapsular hematomas. There was some active bleeding from a small splenic vein radical. There were also hematomas along the anterior and posterior surface of the transverse colon. Only about 100 cc of liquid blood was found in the intraperitoneal space. The left kidney was found to be fractured into two pieces at the junction of the hilum with the lower pole. Splenectomy was performed and a large amount of liquid and clotted blood was removed from the abdominal cavity. Left nephrectomy was performed. Because of considerable oozing in the retroperitoneal space from torn left adrenal veins, a number 100 Gelfoam® sponge was placed in this retroperitoneal area. A Penrose drain was also placed in this space and brought out a stab wound below the primary incision. The peritoneum was closed with continuous 00 chromic catgut suture and the remainder of the abdominal wall was closed in layers with interrupted cotton sutures. The patient received three pints of blood during the first 24 hours post-operatively.

The patient's post-operative course was uneventful except for a spiking fever which commenced on the second post-operative day, and continued to spike through the fourth post-operative day. The patient was discharged on the 10th post-operative day.

The negative abdominal paracentesis in this case points up the fact that a postive abdominal tap is significant and a negative tap means nothing. In retrospect I believe that if the technique of Pfeffer, Mixter, and Hinton[18] had been used, a positive tap would have been obtained.

•

Blunt Abdominal Trauma

Rodney Maingot lists the following order of frequency of nonpenetrating injuries to intra-abdominal viscera:

1. Liver
2. Spleen
3. Small and large intestine
4. Kidneys
5. Stomach
6. Urinary bladder
7. Pancreas[14]

I believe most American authors would place the spleen at the top of this list.

Maingot lists modes of intestinal rupture as follows:

1. By crushing
2. By tearing
3. By compression

Tearing occurs at points of fixation such as the retroperitoneal duodenum, at the ligament of Treitz cecum, and hepatic and splenic flexures of the colon.

Fultz and Altemeier state that delayed rupture of the spleen is the most frequent cause of delayed and obscure intra-abdominal hemorrhage following trauma. It ocurred in 66 per cent of their cases studied.[10]

Diagnosis

The signs and symptoms of intestinal rupture are as follow:

1. Shock
2. Hemorrhage
3. Pain. Initially, the pain is diffuse, then localized, and then becomes diffuse again.
4. Nausea and vomiting. Incessant vomiting is suggestive of intestinal perforation.

5. Tenderness and rigidity. Maingot recommends rectal and vaginal examinations to detect pelvic peritonitis.
6. Shifting dullness in the flanks. This is an unequivocal sign of intraperitoneal injury.
7. Abdominal distension. This is usually a late finding.
8. Emphysema of the abdominal wall. This is found in certain cases of retroperitoneal rupture of the duodenum or of the colon.
9. Auscultation. The abdomen is usually silent.

Laboratory Tests

1. Blood count, urinalysis, and serum amylase and/or lipase.
2. X-ray examinations:
   (a) Chest
   (b) Flat and upright films of the abdomen.
   (c) Left lateral decubitus film of abdomen.
   (d) Gross, microscopic, chemical, and bacterial analysis of intraperitoneal fluid obtained by paracentesis.

William H. ReMine of the Mayo Clinic warns that fractures of the thoracic verterbrae may closely imitate intra-abdominal injuries because of referred sensory pain, tenderness, hyperesthesia, and spasm.[19]

While the patient is being evaluated for all types of injuries, four basic procedures should be carried out.

1. Make certain of an adequate airway.
2. Treat the shock if present.
3. Catheter drainage of the urinary bladder.
4. Institute nasogastric suction.
   (a) to reduce intraperitoneal soiling
   (b) to detect blood
   (c) to reduce incidence of aspiration during anesthesia
   (d) to overcome paralytic ileus

A thorough history is of the utmost importance in assaying the damage done. The patient's past history may also have considerable importance. For example: heart disease, diabetes, or recent cortisone therapy, may alter the management and over-all prognosis of the patient. A complete physical examination should be done if at all feasible.

Injuries to Various Organs

Diaphragm. The left diaphragm is injured more often than the right. The physical examination reveals limited excursions, impaired resonance, circulatory collapse, respiratory embarrassment, and peristalsis heard in the chest. Treatment consists of exploratory thoracotomy with replacement of abdominal viscera and repair of diaphragmatic defect.

Liver. Welch and Giddings reported hepatic injury in 9.5 per cent of their 200 cases of blunt abdominal trauma.[25]

John Morton believes that the relative low incidence of liver trauma as recorded in various hospital series is probably due to death from hepatic hemorrhage at the scene of the accident.[16]

Treatment consists of suture of lacerations or packing. Packing of the wound is a poor second choice.

Small Intestine. Air around the right kidney or air along the right psoas muscle on x-ray films indicates rupture of the duodenum. Surgical treatment consists of suture of perforations or resection of the involved segment. If multiple injuries are present in a short segment or the blood supply is compromised, resection and end to end anastomosis is the treatment of choice.

Colon. Another cause of shock is massive peritoneal soiling with liquid feces. In spite of the most vigorous treatment these patients will remain in shock until the peritoneal cavity has been cleaned out.

Wounds of the cecum and ascending colon should be sutured and a complementary tube cecostomy performed; other surgeons prefer exteriorization of this segment or tangential cecostomy. The more extensive wounds of the ileo-cecal region require resection of the involved segment and are better manged by an immediate ileocolostomy rather than exteriorization.

Wounds of the extraperitoneal rectum are best managed with a proximal feces diverting colostomy, suture of the rectal wound when feasible, and drainage of the presacral space

through a retro-anal incision. It is not necessary nor desirable to excise the coccyx to obtain adequate drainage.

Urinary Bladder and Kidney. Vesical injuries may show hematuria or an apparent anuria with peritoneal irritation and increasing signs of intraperitoneal fluid. A constant desire to void with inability to do so is almost pathognomonic of bladder or urethral injury. Urinary bladder rupture can be readily demonstrated by inserting a French catheter into the bladder and injecting a contrast medium such as Skiodan and then obtaining an x-ray. The resultant cystogram will demonstrate any bladder defect. Most kidney injuries can be managed by nonoperative treatment, unless there is fragmentation of the renal parenchyma or laceration of the renal pelvis.

Spleen. The association of rib fractures with splenic rupture occurs in only about 20 per cent of cases. In children, rib fractures are even less common.[26]

William Altemeier[10] and Robert M. Zollinger[26] claim that delayed rupture of the spleen occurs in approximately 16 per cent, although William H. ReMine[19] of the Mayo Clinic believes that it occurs in 2.5 per cent of cases. John Morton[16] says that the incidence is about 14 per cent and Zollinger states that almost 75 per cent of these delayed ruptures occur during the first 14 days after the initial injury.[26]

James Drye states that an area of increased dullness to percussion which fails to shift or is located over the spleen suggests splenic injury and if it is associated with left shoulder radiation of pain it is highly diagnostic.[8] Zollinger states that pain referred to the left shoulder occurs in approximately 75 per cent of cases.[26]

On roentgenologic examination, displacement of the stomach to the right or indentation of the greater curvature is compatible with enlarging spleen due to bleeding. The treatment is splenectomy.

ReMine at the Mayo Clinic warns that all splenic tissue must bc removed from the peritoneal space because splenic tissue grows rapidly in the peritoneal cavity and multiple splenic implants (splenosis) may occur and result in mechanical obstruction of the small intestine at a later date.[19]

Pancreas. There is often a delay of 24 to 72 hours in onset of complaints. Shock, contrary to most books, is rare except with complete transection, when major vessels are severed.[13] All pancreatic wounds should be drained.

Fistulae are common sequelae. They tend to close spontaneously, provided there is no obstruction to the proximal ductal system.

Abdominal Paracentesis

Indications

(1) In suspected primary and secondary bacterial peritonitis, bile peritonitis, pancreatitis, perforated viscus, mesenteric thrombosis or embolization, chylous ascites, and intra-abdominal hemorrhage.

(2) Suspected carcinomatosis.

(3) In trauma when the history is unobtainable (coma, shock, or alcoholic intoxication).

In acute pancreatitis the peritoneal amylase level is elevated and usually remains elevated several days after the serum level has returned to normal. Therefore, paracentesis is particularly valuable when the patient presents residual signs and symptoms relatively late in the course of pancreatitis with normal serum amylase value. Ellison states that the peritoneal amylase remains elevated for as long as six days following the onset of acute pancreatitis.[9]

Technique

No true contra-indications to paracentesis are known except intestinal obstruction with distension; however, Weakley and Clegg recommend avoidance of masses, scars, and the urinary bladder.[24]

Dr. R. V. Byrne advises abdominal paracentesis as a diagnostic tool and reports an 83 per cent accuracy with this technique. He recommends paracentesis in all four abdominal quadrants.[4] It is valuable only if it is positive. It should be emphasized that a dry tap on abdominal paracentesis does not exclude the presence of severe intra-abdominal visceral injury.

Pfeffer, Mister, and Hinton recommend the insertion of a No. 60 polyethylene catheter through a No. 13 B-D thoracentesis needle if a dry tap is obtained. The use of the flexible

tube averts intestinal injury. The position of the patient is changed to increase the chance of obtaining fluid.[18] One should not remove the tubing through the intact needle because a double or bent piece of tubing may be sliced off. The styleletted needle prevents plugging of the lumen with fat or other tissue.

Prevention of Injury

The American College of Surgeons, the Automotive Industry, and local and State Police Departments are vitally concerned in the high mortality and morbidity in automobile accidents.

A report of the Indiana State Police before the Eighty-Fifth Congress on Crashworthiness of Automobile Seat Belts listed the causes of fatal injury as follows:[23]

1.	Steering wheel assembly	171
2.	Windshield area	146
3.	Instrument panel	154
4.	Projections on instrument panel	11
5.	Interior hardware	12
6.	Door and/or glass framework	280
7.	Seat framework	23
8.	Top structure	98
9.	Floor	7
10.	Unknown	3
11.	Caused outside of car	261
12.	Other (burns, drowning, electrocution, etc)	18
	Total	1,184

Dr. R. Arnold Griswold, representing the Committee on Trauma of the American College of Surgeons before this same session of Congress, made the following statements: "The fear of being unable to get out of a burning or submerged car is exaggerated. Statistics of the Indiana State Police show that less than one per cent of automotive deaths are due to drowning or fire. It is our opinion that an occupant protected by a seat belt would more likely be conscious and better able to extricate himself from a burning or submerged vehicle than would an unprotected occupant, who is likely to be unconscious.

"The undoubted fact that in certain types of high speed impact the safety belt might cause injuries is in our opinion a very feeble objection, when one considers that two-thirds of the deaths occur at speeds under 50 miles per hour, and that if an individual sustains injury from impact against a fabric belt he certainly would have sustained much more severe injury from contact with unyielding metal and glass structures within the car, or objects outside the car if no belt had been worn."[22]

Discussion

Exploratory celiotomy is tolerated very well during the first few hours following blunt abdominal trauma, but prolonged observation prior to celiotomy increases the morbidity and increases the likelihood of mortality. For these reasons it is far better to err on the side of early celiotomy in these difficult diagnostic cases.

I strongly recommend abdominal paracentesis in the difficult diagnostic cases of blunt abdominal trauma. During the last 11 years this procedure has been used at the Louisville Veterans Administration Hospital without a single complication. In a review of the surgical literature I could find no serious complications mentioned. [3, 5, 6, 7, 11, 12, 15, 17, 20, 21]

Summary

(1) Intra-abdominal injuries due to blunt abdominal trauma are discussed.
(2) Three cases illustrating serious sequelae due to blunt abdominal trauma in automobile accidents are presented
(3) A plea is made for employing abdominal paracentesis in the difficult diagnostic cases of blunt abdominal trauma.
(4) The value of safety seat belts is stated.

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The Use Of Hypnosis In Pediatric Anesthesia*

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Lexington, Ky.

In approximately 90% of the children studied, hypnosis provided at least a part of the tranquility needed to permit the induction of general anesthesia with minimal psychic trauma

HYPNOSIS, in an increasing number of reports, has been advocated as either a complete substitute for or as an adjunct to chemical anesthesia. It has been noted that children are particularly good hypnotic subjects. In fact, many of us use modifications of hypnosis with children now.

Hypnosis can provide rapport, tranquility, relaxation and relief from anxiety. It can provide these things without the price that must be paid when chemical agents are employed in heavy doses to produce the same results. Its principal disadvantages are the time required for induction and utilization of the trance state and the fact that some persons are resistant to hypnosis. Children, in general, are able to go into hypnosis with ease, since they have not lost or had destroyed their normal curiosity and willingness to accept new things. This ease of induction is fortunate because children need a great deal of psychological support to face the mental stresses of anesthesia and surgery.

The anesthesiologist in partnership practice in a general hospital with a full surgical schedule and a large number of emergencies has little time to devote to establishing rapport of the type that is necessary for the handling of children. Many times he will be giving an anesthetic while his partner is making preoperative rounds and will first meet his patient on the stretcher outside the operating room.

If one utilizes chemical methods to achieve tranquillity and relaxation to avoid psychic trauma, the price of these drugs in respiratory and circulatory depression and prolonged postoperative somnolence must be paid. Fortunately, children are unusually susceptible to rapid induction of a hypnotic trance with the proper techniques.

Technique

In a series of 126 children the following method was used. The usual preoperative visit was made the night before surgery. Admission the day of surgery, even for afternoon cases, was discouraged as much as possible. A simple explanation was given of the occurrences that would happen the next day. Appropriate premedication in moderate doses of a barbiturate and a belladona derivative with or without the addition of an opiate was ordered.

On arrival in the operating suite hypnosis was induced. The usual method of induction utilized some of the most familiar things in a child's life. Virtually every child is addicted to television. Indeed the mere mention of the word "TV" is enough to induce a very slight trance in many children and in some adults too. The child's viewing preferences are ascertained and with the aid of appropriate suggestions he is persuaded to visualize his favorite program. This is a standard hypnotic induction technique known as "Visual Imagery." Incidentally, the most popular programs today according to my statistics are the Saturday morning trio of "Howdy-Doody," "Ruff and Reddy," and "Fury." Once the trance is established, general anesthesia is induced while postoperative suggestions of well-being are given.

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Results

One hundred twenty-six (126) children were managed in this fashion. Their ages ranged from 3 to 15. Seventy-four (58.7%) developed definite trances, 40 (31.8%) were considered to have reached a hypnoidal level in that they were relaxed and calm or showed other signs of early hypnosis. However, they failed to visualize the suggested TV program and were not considered to have been completely induced. Twelve (9.5%) were considered failures in that the attempt at hypnotic induction did not succeed and there was little relaxation or tranquillity. Five minutes was usually all the time required to induce the trance and at no time was the surgical schedule delayed while hypnosis was being done.

Discussion

Anesthesia can be a very frightening thing to a child. There are many methods of easing and relieving his fears. Hypnosis is one that appears to offer a quick, relatively simple nontoxic means for gaining rapport and quieting the child. It diverts the child's attention from the terrifying paraphernalia of anesthesia, and with simple suggestion places him in the imaginary, familiar and friendly world of television. In good subjects, postoperative courses can be made more comfortable and with sufficient time even the chemical anesthetic can be completely replaced.

Below the age of 5, difficulty of hypnotic induction increases. Establishing communication and rapport is more difficult. The child's attention span is shorter and his ability to follow the necessary suggestions is less. Above the age of 10 or 12 the child loses his belief in magic and Santa Claus and therefore is not willing to follow the simple suggestion that he close his eyes and watch television. He is maturing enough to want explanations of the process similar to those given adults. These take time and therefore limit the use of hypnosis to selected cases as in adult hypnosis. Between these ages, hypnosis provides an almost miraculous rapport with amazing rapidity in many cases.

Hypnosis has been reported to reduce uniquely the amount of chemical drugs needed for anesthesia. Except when hypnotic anesthesia is deliberately attempted, I doubt if this can be considered a property peculiar to hypnosis. Certainly many of us have seen both the severely frightened patient who requires higher concentrations of anesthesia and the calm relaxed patient who seemed to run on virtually no anesthetic.

Hypnosis reduces tensions and fears and this appears to reduce the amount of anesthetic necessary. The same result can be accomplished by other methods, although perhaps not as rapidly and with such universality.

Approximately 90 per cent of children of the ages from 5 to 10 or 12 can be rapidly induced into a hypnotic trance or at least achieve a relaxation and distraction sufficient to permit the induction of general anesthesia with minimal psychic trauma. The use of premedication in moderate doses probably helps this process by speeding it up and enabling the anesthesiologist to expect fairly consistent success. There appears to be no contraindication to the use of hypnosis for this purpose. No special skill is required beyond that of learning proper communication and verbalization. Even if formal hypnosis is not used by the anesthesiologist, the ability to meet the child on his own level and to enter into his world are invaluable, and hypnosis is merely an extension of this.

The Difficult Children

There are some children in whom hypnosis is difficult to induce rapidly. The child without a TV set is one. In his case, a short exploration into his favorite activities will usually provide a suggestion for use as a picture to visualize. The mentally defective child is difficult. The frightened, screaming child who has not had a preoperative discussion with an anesthesiologist and is brought into the hospital and immediately taken to surgery without allowing him to become accustomed to his environment is difficult. In his case, if the time is available rapport can be established; but it is not as simple and easy as with the properly prepared child.

Hypnosis will not replace chemical anesthesia. It is simply another easily used agent, another adjunct which can be used when it is needed. It is only a means to an end, the provision of a comfortable, non-frightening visit to the operating room for a defenseless child.

Summary

Routine, rapid hypnotic induction to general anesthesia was attempted on 126 children ranging in age from three to fifteen. Seventy-four (58.7%) developed definite trances. Forty (31.8%) attained a hypnoidal level. Twelve (9.5%) were unsuccessful. Thus in 90.6% of the children hypnosis was considered to have been used successfully. A simple, easily usable induction technique is described involving the visualization of a favorite television program. The advantages of hypnosis for use as a "preanesthetic drug" are discussed.

Mumps Virus Simulating Paralytic Poliomyelitis

The authors report on 11 boys, aged from 2½ to 8 years who were clinically considered to have mild paralytic poliomyelitis but in whom there was clearcut serologic evidence of mumps virus infection. Poliomyelitis viruses were not isolated from the stools, and complement-fixing and neutralizing antibodies to poliomyelitis were either absent or did not significantly change in titer between the acute-phase specimens and the convalescent-phase specimens of serum. Clinically, fever, headache, muscle pain, and slight to moderate weakness of several muscle groups were prominent manifestations. The cerebrospinal fluid uniformly contained over 100 leukocytes, and commonly over 300, predominantly lymphocytes. Only 2 of the 11 patients showed evidence of parotitis and in these parotitis did not antecede the manifestations of the central nervous system. Electroencephalograms were made on 8 patients, and the recordings were abnormal in 3. All the 11 patients had evident muscle weakness at the end of the acute phase of illness, and 4 had slight residual weakness on convalescent examination 2 to 5 months after the onset of illness. There was no significant predilection for any muscle group. These observations emphasize that involvement of the central nervous system with the virus of mumps may be manifested as a syndrome of meningomyelitis and it may be erroneously diagnosed as paralytic poliomyelitis. Weakness is usually highly transitory, but residual involvement may persist for some months. As the incidence of paralytic poliomyelitis is reduced by widespread immunization, mumps virus may assume increasing relative importance as a cause of "poliomyelitis-like" disease.

—E. H. Lennette and others; Pediatrics, Springfield, Ill., (May) 1960, page 788.

Current Clinical Status Of Regional Enteritis After Three Decades*

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This nonspecific granulomatous condition, while usually affecting the terminal ileum, may involve any area of the gastrointestinal tract. Resection is the eventual treatment

On May 13, 1932, Crohn, Ginzburg and Oppenheimer presented a paper before the Section on Gastroenterology and Proctology of the American Medical Association in New Orleans, entitled "Regional Ileitis: A Pathological and Clinical Entity."[1] It has been nearly 30 years since this epochal contribution, and sufficient experience of this condition has accrued to justify an appraisal of our current knowledge.[2,3]

Regional enteritis, initially suggested by Brown, Bargen and Weber, appears a logical term inasmuch as the disease may involve any segment of the gastrointestinal tract.[11] Regional enteritis affects mainly young adults and is characterized by abdominal cramping pain, diarrhea, fever, loss of weight, anemia and perianal abscesses and fistulas. Rectal bleeding, however, is not a common clinical finding. The lesions are generally limited, both in the initial and recurrent cases, to the terminal ileum.

Pathologically, regional enteritis is a granulomatous, necrotizing, ulcerating and cicatrizing process with fistulas from the lesions to other viscera, the abdominal wall or the perianal region. The condition consists of mesenteric lymphatic obstruction and congestion and a non-specific inflammatory alimentary component.

Etiology and Pathogenesis

The cause of regional enteritis is unknown. While initially suspected and implicated as etiological factors, tuberculosis, collogen-diseases, various bacteria, reticulosis, mesenteric lymphadenitis, talc, virus infection, lipids, psychogenic factors, appendicitis, relationship with chronic ulcerative colitis, allergy, bacterial infections, trauma, protozoa, lymphogranuloma venereum, sarcoidosis and heredity or familial traits can be reasonably excluded. Regional enteritis has not been successfully reproduced in experimental animals.

Pathology

Regional enteritis generally involves an abbreviated segment of the terminal ileum, characteristically spreads in a cephalad manner, and occasionally distal extension may be found. The appendix may also be involved, particularly in the acute phase. Discontinuous "skip-areas" of involvement of both the small and large intestine have been described. Ileojejunitis and enterocolitis are, therefore, clinical and pathological descriptive terms of regional enteritis.[16, 18, 26, 27, 29-31]

Typically, regional enteritis is an area of indurated, demarcated, congested, proliferative, granulomatous intestine which is discolored red, purple or gray, and is attached to a thickened, stiff, edematous mesentery containing enlarged

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soft lymph nodes. Acute regional enteritis, clinically indistinguishable from acute appendicitis, for example, is usually remissive. It affects and scleroses lacteals in the lamina propria of the intestine beneath the epithelium of the intestinal glands and also affects the intestinal submucosal, muscular, and subserosal layers. This obliterative lymphangitis produces lymphangiectasis of the intestinal wall, mesentery, and regional lymph nodes.[6, 7, 15] This leads to mucosal ulcerations.

Focal granulomas, which may contain giant cells, are observed in the affected intestine and lymph nodes. An appreciable incidence of peritonitis, fatty liver, amyloidosis, portal cirrhosis, glomerulitis and renal tubular degeneration, which may be found in any debililating condition, have been reported.[24]

In comparing the hepatic complications of regional enteritis with chronic ulcerative colitis, it was found that pathological lesions of the liver were common in the later condition and infrequent in regional enteritis.[25] After three decades it is concluded that regional enteritis is a distinct pathological entity.

Clinical Description

Characteristically, regional enteritis appears to be a smoldering, subclinical condition with occasional exacerbations of diarrhea, malaise or fistula-in-ano. Gradually, a nonsanguinous diarrhea develops, increasing in severity and intensity, associated with intermittent partial intestinal obstruction, manifest as cramping lower abdominal pain, low-grade fever, impaired appetite, loss of weight, palpable mass in the right lower quadrant of the abdomen and intestinal fistulous tracts.[4, 5, 12, 14, 21]

Perirectal abscess and fistula are characteristic of regional enteritis. Occult rather than overt gastrointestinal hemorrhage is common. After clinical remissions and exacerbations of regional enteritis occur, intestinal obstruction may be observed. Laboratory tests are not diagnostic, but iron-deficiency anemia, leukocytosis, hypoalbuminemia, and increased erythrocyte sedimentation rate are frequently present.

Other general conditions associated with regional enteritis are cachexia, retarded growth, "intestinal-infantilism," arthritis, and sometimes a prominant functional overlay. Familial cases or associated intestinal neoplasm are occasional and appear to be coincidental.

Physical examination usually presents three outstanding features, namely, an abdominal mass, internal or external fistula formation and loss of weight or malnutrition. According to the authoritative observations of Crohn, fistula formation is the most constant clinical and pathological phenomenon of regional enteritis.[2, 3] This consists of three types of fistulas: one to the anterior abdominal wall; internal fistulas between loops of bowel and adherent hollow viscera, and rectal and perirectal fistulas. The malabsorption syndrome may occur in regional enteritis, particularly ileojejunitis or following a surgical resection of intestine representing a defect in the absorptive capacity of the small intestine.[9, 33] When regional enteritis is active, pregnancy exerts an unfavorable effect upon the clinical course and health and well-being of the mother.[10, 22]

Methods Of Detection

Regional enteritis is best observed radiologically with the use of the barium enema. The only reliable method to detect involvement of the duodenum and jejunum is a "barium swallow" or employing the peroral intestinal suction biopsy instrument. The roentgenological sprue pattern and overt steatorrhea are uncommon in the usual cases of regional enteritis.

The radiographic diagnosis of regional enteritis has been conveniently divided into two stages, the nonstenotic and the stenotic. In the former, the small intestinal mucosa is blunt, flattened and thick with irregular widths of the intestinal lumen. Longitudinal streaks of barium suggest mucosal ulcerations. When further mucosal destruction occurs, a cobblestone-pattern is observed. In the stenotic phase, the loops of involved intestine resemble a rigid, thick pipestem with alternate constriction and dilatation of the intestinal wall. This resembles a cast. A "string-sign" is most frequently noted in the terminal ileum. While spontaneous clinical remissions and improvement occur, the radiologic appearance of the involved intestine is progressively stenotic.



Figure 1



Figure 2



Figure 3

Figures 1, 2 and 3—Roentgenograms of the upper gastrointestinal tract immediately after a barium swallow, one hour later and four hours later, in a case of regional enteritis involving the entire duodenum. Note mucosal polypoid defect of the duodenum and segmentation, clumping and feathering of the jejunum and ileum.

Case History

A 24-year-old male student complained of generalized cramping abdominal pain of six years' duration. The abdominal pain had become more intense and more frequent. It appeared within a few minutes after the ingestion of any type of food. He had lost 32 pounds. There was a progressive loss of appetite, weakness, and bouts of nausea and vomiting invariably followed a meal. There was gradual change in bowel habit. The stools were soft, not discolored, and the patient had two to five bowel movements a day. Over a period of five years the patient had been diagnosed amebiasis, rectal abscess and fistula, duodenal ulcer, and mucous colitis. In addition, during the past four years the patient had been under treatment by three different psychiatrists for a presumed, though unconfirmed, psychosis.

Physical examination disclosed marked underweight. The hemoglobin was 11 grams per 100 c.c. of blood; hematocrit was 39.5 per cent; leukocyte count was 10,000 per cu. mm.; erythrocyte sedimentation rate was 59 mm. per hour (Westergren). The urinalysis, blood urea nitrogen, serum calcium, serum phosphorus, serum albumin, serum globulin, bromsulfalein dye retention, blood carbon dioxide capacity, serum chloride, serum sodium, serum potassium and fasting blood glucose were normal. Roentgenograms of the chest, esophagus, stomach and colon were normal. Serial roentgenograms of the small intestine revealed that the mucosal folds of the entire duodenum were exaggerated, had a polypoid appearance, and that the mucosal pattern, particularly in the third and fourth portions of the duodenal loop were defective. (Figures I, II, and III).

During fluoroscopy there was reverse peristalsis from the tender duodenum. Barium was retained in the duodenal loop at the end of two hours, although most of the barium had passed along the small bowel and reached the terminal ileum by this time. The lower small bowel segments appeared normal. Re-examination of the duodenal loop 24 hours later revealed similar findings.

A gastrojejunostomy was performed in preference to a radical resection. Exploration of the duodenum revealed the first and second portions to be markedly thickened and to contain hyperplastic polyps. Histological examination of the duodenal biopsy disclosed extensive edema, fibrosis of the interstitial tissue, hyperplasia of the mucosal and Brunner's glands, a diffuse inflammatory reaction consisting of eosinophils, and numerous round cells, and granulomata in the submucosa (Figure IV and V). Bacterial and viral cultures, including mycobacterium study, were normal. Seven years later the patient continued to be in good health.

Medical and Surgical Treatment

The medical treatment of regional enteritis is applicable to four types of patients: (1) mild disease in the absence of intestinal obstruction or perforation; (2) disease too complicated and extensive for resection; (3) those in whom recurrence of regional enteritis and repeated resection have reduced the length of the small intestine producing malassimilation and malabsorption and; (4) ileojejunitis.

Medical treatment is symptomatic and supportive and consists of dieto-therapy (2500-3500 calorie high protein, moderate residue diet), antibiotics, salicylazosulfapyridine (Azulfidine), calcium and reasonable courses of adrenal corticosteroid therapy. Bargen has advised abdominal roentgenotherapy administered monthly at three or four intervals.[17] In many instances, this perpetuates intestinal cicatrization, leading to surgical treatment.

Surgery Best Limited

Surgical treatment of regional enteritis affords better treatment, but the recurrence rate after resection, in general, is very high. Surgical treatment is best limited to those patients with regional enteritis who have complications of this condition, which medical management will not satisfactorily control.[8, 10, 13] These are intestinal perforation, internal and external fistulas, intestinal obstruction, severe malnutrition, recurrent enteritis, uncontrolled intestinal hemorrhage and anemia, and complications such as arthritis, hepatic abscesses and amyloidosis. There is little reason to make a patient with regional enteritis an "intestinal-cripple," manifest by severe malabsorption syndrome.

The type of operative procedure chosen depends at the present date on the surgeon's school of thought and also upon the risk of the patient. The majority of clinicians and surgeons prefer primary resection to the short-circuiting procedure, usually an ileo-transverse-colostomy with transection of the ileum. A blind loop of intestine, however, should be avoided because this may produce a hemorrhagic or megaloblastic anemia or become obstructed. Despite the moderately increased recurrence rate of regional enteritis and increased mortality following resection in regional enteritis, experi-

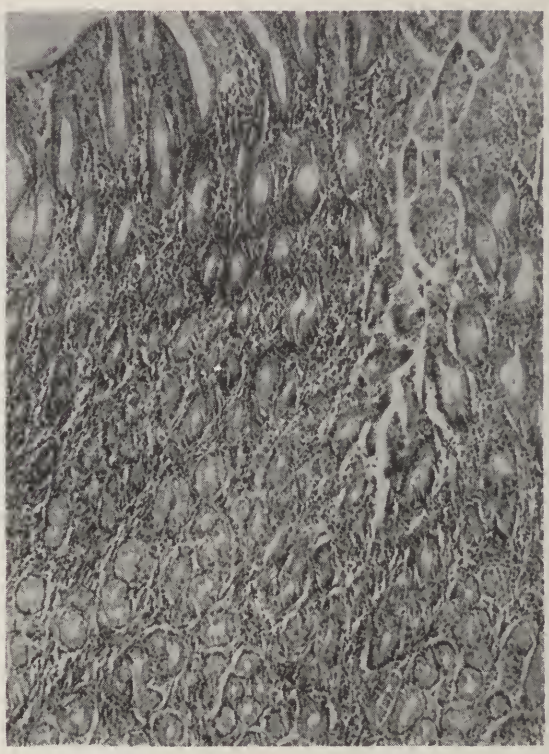


Figure 4
Duodenum of chronic regional enteritis showing chronic inflammation of the mucosa and submucosa and around Brunner's glands. H. & E. X 80

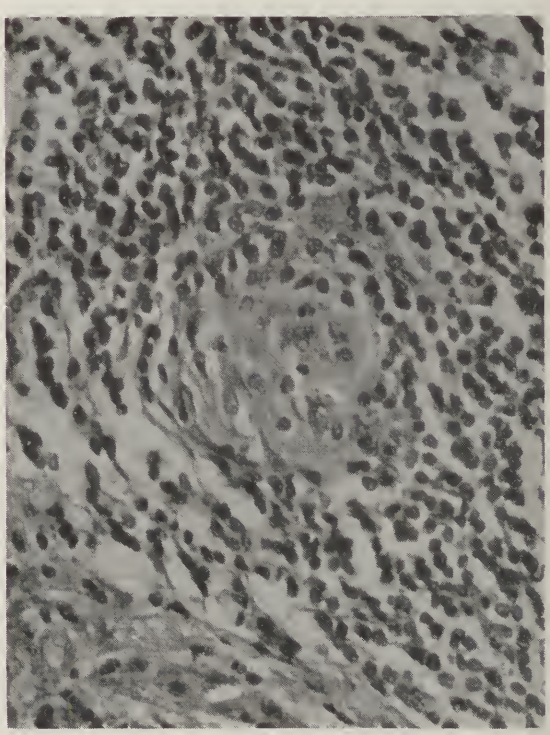


Figure 5
Duodenum of chronic regional enteritis showing granuloma and giant cells in submucosa, H. & E. X 400

enced surgeons generally favor this procedure. The recurrence rate following primary resection is from 15-50 per cent, particularly in young people.[1, 2, 19, 20, 23, 32] It should be adequately considered whether the recurrence is "clinical" or "radiological," and whether the diseased intestine has been completely resected, when considering the value of primary resection.[23]

It is difficult to explain the pathogenesis of recurrent regional enteritis after a normal small intestine is anastomosed to a normal colon. For this reason, at the time of resection particular care should be taken by gross examination and frozen histological sections to delineate abnormal from normal intestine.

Fortunately, most cases of recurrent regional enteritis are mild and can be managed by medical treatment. In this instance and also in ileojejunitis, adrenal corticosteroid therapy offers some benefit.[10] The problem in the management of regional enteritis is not solved completely by surgery. Continuous medical management is necessary in almost all of the patients.

Summary and Conclusion

Regional enteritis is a nonspecific granulomatous disease which may involve any region of the gastrointestinal tract. The terminal ileum is most commonly affected. This condition occurs usually in young people, and the clinical course may be smoldering, latent, remissive or recurrent. The etiology remains obscure.

The diagnosis is made on the basis of a history of cramping abdominal pain, loss of weight, diarrhea, and abdominal mass, internal and external fistulas, weakness, malnutrition and intestinal obstruction. A roentgenogram will usually confirm the diagnosis. Systemic complications are not uncommon. Medical therapy is nonspecific and supportive. Surgical intervention is necessary for the treatment of the complications due to the natural progression of the disease.

Despite resection or exclusion operative procedures, the rate of recurrence is high, especially in the younger individuals. Most surgeons believe that resection is the eventual treatment of choice in the management of regional enteritis.

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Chronic Idiopathic Jaundice

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A case of Chronic Idiopathic Jaundice (Dubin-Johnson Syndrome) in a 54-year-old white male is reported. This syndrome should be considered in any jaundice of obscure etiology

A FIFTY-FOUR-year-old white male was seen because of persistent jaundice following cholecystectomy six weeks earlier. The surgeon reported that at surgery the gallbladder appeared normal and contained a solitary cholesterol stone. The common duct was normal. The liver was described as appearing dark and congested and a liver biopsy was taken. The slides were interpreted by the pathologist as showing only hemosiderosis at that time.

The patient related that for several months prior to surgery he experienced recurrent episodes of epigastric and right upper quadrant abdominal pain and was clinically jaundiced on two occasions. He had also noted dark urine with these episodes. Oral cholecystography revealed non-visualization of the gallbladder on two occasions prior to surgery. Review of an admission to another hospital 18 months earlier revealed that a double dose oral cholecystogram showed non-visualization and a bromsulphalein test was reported as showing 28% retention at 45 minutes. The patient was not jaundiced at this time.

Physical examination on admission to the hospital revealed icterus of the sclera. There were no stigmata of liver disease noted. The liver and spleen were not palpable.

Laboratory data: CBC and urine analysis were normal except for bile in the urine. Blood urea nitrogen and post-prandial blood sugar tests were normal. Two serum bilirubin determinations were, respectively, 3.4mg.% total with a direct of 2.1mg.% and 2.4mg.% total with a direct of 2.1mg.%. Two alkaline phosphatase determinations were normal. The cephalin flocculation was negative at 24 and 48 hours and the thymol turbidity was 5.5 units. The values for the serum proteins, serum iron, serum glutamic oxalacetic transaminase and prothrombin time were within normal limits.

The liver biopsy slides were reviewed. Special staining indicated that the pigment in the liver cells was neither hemosiderin nor bilirubin. Except for this pigment, the liver was histologically normal. Since the clinical and laboratory features along with the liver pigmentation suggested chronic idiopathic jaundice, the liver slides were sent to Doctor I. N. Dubin in Philadelphia who confirmed the diagnosis in a personal communication.

Discussion

Chronic idiopathic jaundice (Dubin-Johnson or Dubin-Sprinz Syndrome) is of fairly recent discovery. It was first described, independently, by Dubin and Johnson[1] and by Sprinz and Nelson[2] in 1954. Since that time, a number of case reports have appeared in the literature. Males have predominated. Only two cases have been reported in Negroes.[3] Dubin,[4] in 1958, presented a review of the 50 cases reported to that time.

This syndrome is characterized by fluctuating jaundice, episodes of abdominal pain, anorexia, nausea and vomiting, easy fatigability, enlarged liver and dark urine. The serum bilirubin may range between 2.4 and 19mg.%. Abnormal bromsulphalein retention is a constant feature and oral cholecystography almost always shows non-visualization of the gallbladder. Histologi-

cally, the most striking finding has been the coarsely granular, brown pigment within the centrolobular liver cells. The liver is otherwise of normal appearance microscopically. (Figure 1)

The syndrome has been reported in a wide age range of from 4 to 76 years. More recent studies have demonstrated a definite familial tendency in some cases.[5, 6] Liver function tests are usually normal, though in about 50 per cent of the cases the cephalin cholesterol flocculation and thymol turbidity become abnormal during times of jaundice and return to normal when the jaundice clears. In most cases, the onset of jaundice is insidious or precipitated by intercurrent disease. Once the disease is manifested, it is apparently life long.

The pigment in the liver cells is probably a lipofuscin. It is known that liver cells store and excrete lipofuscins and it is likely that the accumulation of these pigments in the liver cells results from defective excretion of lipofuscins. The accumulation of these pigments in the liver cell causes the liver to be grossly enlarged and dark in color.

Further evidence that the basic liver defect is an excretory one is the bromsulphalein retention and the direct bilirubinemia. The direct bilirubin accounts for about 60 per cent of the total serum bilirubin. This would indicate that the liver is capable of conjugating bilirubin but then is unable to excrete it normally into the bile.

There is no specific treatment for this condition. The prognosis appears excellent on the basis of the long duration of the disease in many patients and the absence of progressive hepatic damage in the cases that have been followed to date. The patient should be reassured of this. Liver biopsy, in a suspected case, is the main diagnostic tool. The finding of coarsely granular, brown pigmentation within the centrolobular liver cells in an otherwise normal liver is pathognomonic.

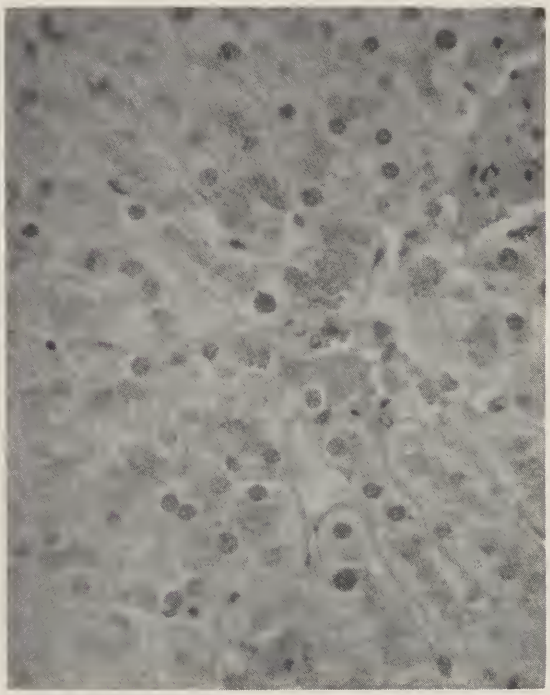


Figure 1

High-dry power field of the liver biopsy showing the pigment within the liver cells and its centrolobular distribution. (Photograph courtesy of John D. Allen, Jr., M.D.)

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Predominant Role Of the Physical Examination In Cardiovascular Diagnosis

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Despite extensive development of laboratory and other technical procedures, the physical examination plays a predominant role in many phases of cardiovascular diagnosis

MANY years ago, medical diagnosis was limited to bedside observation. Then, medical science contributed the laboratory study. During the recent past, the meager advances in physical diagnosis have been overshadowed by mountains of technical procedures. The evolution of medicine appears to be increasingly toward displacement of observation and judgment. Yet, broad areas of medicine still depend primarily upon clinical observation for diagnostic exactness. This is, not surprisingly, true of dermatological disease, where the pathology is subject to direct vision. It is also true of many diseases of such internal organs as the heart and blood vessels.

Evaluation of Functional Capacity

One aspect of cardiological diagnosis, with respect to which the physical examination has basic importance, is evaluation of the functional capacity of the heart. It is true that the cardiac catheterization and dye dilution techniques yield relatively accurate values of the cardiac output. However, these determinations are difficult during exercise. In addition, they fail to take human attitudes into consideration. In the final analysis, functional capacity depends as much upon human willingness as upon organic pathology.

A surprisingly large range of activities is within the capacity of people with pathological hearts.[1] Much more, therefore, can be learned of the actual capacity of the heart in everyday activities by observation of the patient than by technical studies of the cardiac output. The classifications of cardiac capacity promulgated by the American Heart Association recognize this fact.[2]

Diagnosis of Heart Failure

Like the capacity of the heart as a whole, the separate functioning of the right and left sides of the heart lends itself readily to evaluation by the physical examination. It is true that technical procedures may support the diagnosis of heart failure. The chest X-ray, for example, may show enlargement of the heart, prominence of the hilar shadows and increased pulmonary markings. The electrocardiogram may show right or left ventricular hypertrophy. The venous pressure may be elevated and the circulation time prolonged. Serum electrolytes may be abnormal. But while abnormal technical results indicate that conditions are consistent with the existence of heart failure, the actual diagnosis is made by the physical examination.[3]

Particularly important is the general clinical impression of the patient, including his respiratory pattern and degree of restlessness and discomfort. The protodiastolic gallop rhythm, tachycardia, orthopnea, pulmonary rales, accentuation of the second pulmonic sound, cyanosis, hepatic enlargement, venous distension, ankle

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edema, ascites, and subcutaneous edema all enter into the diagnosis.

The physical examination is ordinarily more sensitive than technical procedures in the determination and differentiation of early ventricular failure. After establishment of the diagnosis of heart failure, clinical observation permits facile follow-up, with lessened necessity for recurrent resort to expensive technical procedures.

Auscultation

The physical examination predominates in the diagnosis of many structural as well as functional abnormalities of the heart. The phonocardiogram provides useful adjunctive information, but the visual tracing of a sound is not at all equivalent to the sound itself, just as reading a sheet of music is not the same as listening to the actual performance. The thrills and murmurs which accompany stenosis and insufficiency of the mitral and aortic valves have distinctive characteristics. The same is true of the pericardial friction rub. The patent ductus arteriosus is a congenital lesion which can be diagnosed from the machinery murmur.

Auscultation is suggestive of many other congenital abnormalities, but is not in itself diagnostic of them. The auscultatory findings concerning cardiac structure are frequently supported by examination of the peripheral circulation. A wide pulse pressure and water-hammer pulse, for example, occur with aortic insufficiency, while a narrow pulse pressure, a pulsus paradoxus, and venous distension, together with very distant heart sounds, suggest chronic constrictive pericarditis.

The state of the blood vessels and peripheral circulation is mainly evaluated by the physical examination. Measurement of the blood pressure at the arm with a cuff is as reliable, for ordinary purposes, as the more exact intra-arterial determination.[4] Important indications of the vascular effects of hypertension and arteriosclerosis are found in the fundus of the eye. The arcus senilis indicates the existence of arteriosclerosis. The appearance and temperature of the hands and feet and the pulsations in the extremities show the degree of circulatory insufficiency and the site of blockage.

Carotid sinus sensitivity may explain many episodes of syncope or near syncope. The diagnosis of orthostatic hypotension depends upon a low level of blood pressure in the erect position. Prostration, tachycardia, cold sweating, low blood pressure, and a narrow pulse pressure are compatible with hemorrhagic shock. Elevated blood pressure in the arms and weak pulsations and low pulse pressure in the legs suggest coarctation of the aorta.

A disease embraces both functional and structural abnormalities in the heart and peripheral circulation. Physical findings are of basic importance in the diagnosis of many cardiovascular diseases. This is partly due to the difficulties which limit direct examination and biopsy of the heart.

Arthritis, fever, subcutaneous nodules, chorea, a pericardial friction rub, and heart murmurs are suggestive of active rheumatic heart disease. The ordinary contributions of instrumentation to the diagnosis are prolongation of the P-R interval of the electrocardiogram, elevated sedimentation rate, a positive C-reactive protein, and a high anti-streptolysin titer. All of Jones's major criteria for the diagnosis of active rheumatic fever center about physical findings.[5] In the case of subacute bacterial endocarditis, changing heart murmurs, fever, and petechiae are important.

The physical examination is basic in the diagnosis of cardiac abnormality associated with such generalized diseases as hemochromatosis and scleroderma. In these instances, the physical findings point to the over-all diagnosis, and the cardiac abnormalities are strongly presumed to fit into the same category.

Shortcomings of Physical Examination

It is true that the physical examination plays a secondary role in the diagnosis of many cardiovascular abnormalities. For example, the size and shape of the individual cardiac chambers are much more accurately determined by X-ray techniques than by percussion of the chest. Again, the electrocardiogram excels in the unraveling of cardiac arrhythmias.

Such physical findings as the pulse deficit in auricular fibrillation, transmission of the rapid auricular contractions into the cervical veins in auricular flutter, and variability of the first heart sound in complete atrioventricular block are of minor diagnostic value as compared with the electrocardiographic findings. Similarly,

arteriosclerotic heart disease with coronary artery insufficiency and angina pectoris or myocardial infarction is mainly diagnosed by analysis of the history, by means of electrocardiographic changes at rest and during the Master's test, and by increases in the sedimentation rate and serum glutamic oxalocetic transaminase.

That the physical examination has shortcomings in the diagnosis of cardiovascular disease is not surprising. What is unexpected, in this day of the electronic and chemical approach, is that the diagnosis of so many abnormalities of the heart and circulation depends predominantly upon physical findings. The eyes, ears, and touch of the physician are not yet obsolete.

Summary

The physical examination plays a predominant role in many phases of cardiovascular diagnosis, despite extensive development of laboratory and other technical procedures. It has basic importance in evaluation of the functional capacity of the heart as a whole, and of the separate functioning of the right and left ventricles. Many specific structural abnormalities of the heart and peripheral circulation, as well as the underlying disease processes, are diagnosed predominantly by means of the physical examination.

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Neurologic Complications of Cardiac Surgery

Preoperative and postoperative neurologic examinations were performed on 55 patients who underwent surgery of the heart or adjacent great vessels. Nervous system involvement appeared postoperatively in 15 patients. Only 6 of these neurologic complications were initially recognized by the surgeons and cardiologists who administered postoperative care. The complications may be classified into 5 groups. (1) EMBOLIC complications were noted in 2 patients operated upon for mitral stenosis. (2) ANOXIC complications (convulsions, disturbances of consciousness, etc.) occurred in 6 patients operated on for a variety of cardiac lesions. (3) MECHANICAL complications (Horner's syndromes and a left recurrent laryngeal nerve palsy) were found in 3 patients following coarctation and patent ductus surgery. (4) POSITIONAL complications (left brachial plexus involvement) occurred in 3 patients. (5) MISCELLANEOUS complications were noted following insertion of a Hugnagel valve and extracorporeal circulation.
—A. Silverstein and H. P. Krieger; Archives of Surgery, Nov. (1960), page 601

CASE DISCUSSIONS
From The
University of Louisville Hospitals

The Children's Hospital

Erythroblastosis

Case Presentation

DR. STILES W. ALLEN—Baby Girl J. was born on January 7, 1960, as the product of a full term pregnancy. The mother is a 28-year-old white, Rh negative, para 3, gravida 4 white female. The father is known to be homozygous Rh positive. The mother's health had been good during her pregnancy.

The family history of this infant is of importance. The first child of this couple was born in August 1954 and experienced no difficulty. The second child was born in January 1957 and had a positive Coombs test at birth and an indirect serum bilirubin of 3.17 mgm./100 ml. by the third day of life. The baby was felt to have mild erythroblastosis fetalis but required no treatment. The third child, born a year later, had a positive Coombs test and a hemoglobin of 10 grams/100 ml. on the cord blood. This child required one exchange transfusion and subsequently did well.

The maternal anti Rh antibody titre was 1:64 at term in the third pregnancy and had risen to 1:128 at term in the case under discussion. It was anticipated that this child would be rather severely affected by erythroblastosis fetalis and labor was induced at 37 weeks gestation. Labor and delivery were otherwise uncomplicated. The infant appeared pale at birth but was otherwise normal. The cord hemoglobin was 8.2 gram/100 ml. and the Coombs test was positive. The cord indirect bilirubin was 4.2 mgm./100 ml.

This infant subsequently required two additional exchange transfusions, of 500 ml. each, the second at 16 hours of age and the third at 60 hours of age. Figure 1 illustrates the progress of the bilirubin during this child's hospital course.

During the three exchange transfusions the venous pressure never exceeded 90 mm. of blood. The baby's condition remained good throughout the hospital course. Oral feedings of glucose water were begun at 16 hours of age and formula was begun at 36 hours. The child has remained well since discharge with the exception of a submandibular abscess which occurred at 7 months of age and required surgical drainage.

Discussion

Dr. Alex J. Steigman, Chairman
Department of Pediatrics
Dr. Joseph A. Little, Physician-in-Chief
Children's Hospital
Dr. Stiles W. Allen
Chief Resident in Pediatrics

Dr. Steigman—This case serves to point out many aspects of Erythroblastosis Fetalis. It emphasizes the importance of early recognition and prompt treatment if a severe case is to be successfully managed.

We were told that the third child of this couple was erythroblastotic and required exchange transfusion, so, when this Rh negative mother again became pregnant, it was anticipated that the resulting offspring would be rather severely affected. This event was made even more likely by the fact that the father was homozygous Rh positive. The maternal anti Rh antibody titre rose from 1:64 to 1:128 during the fourth pregnancy which also supported the belief that the infant would be rather severely affected.

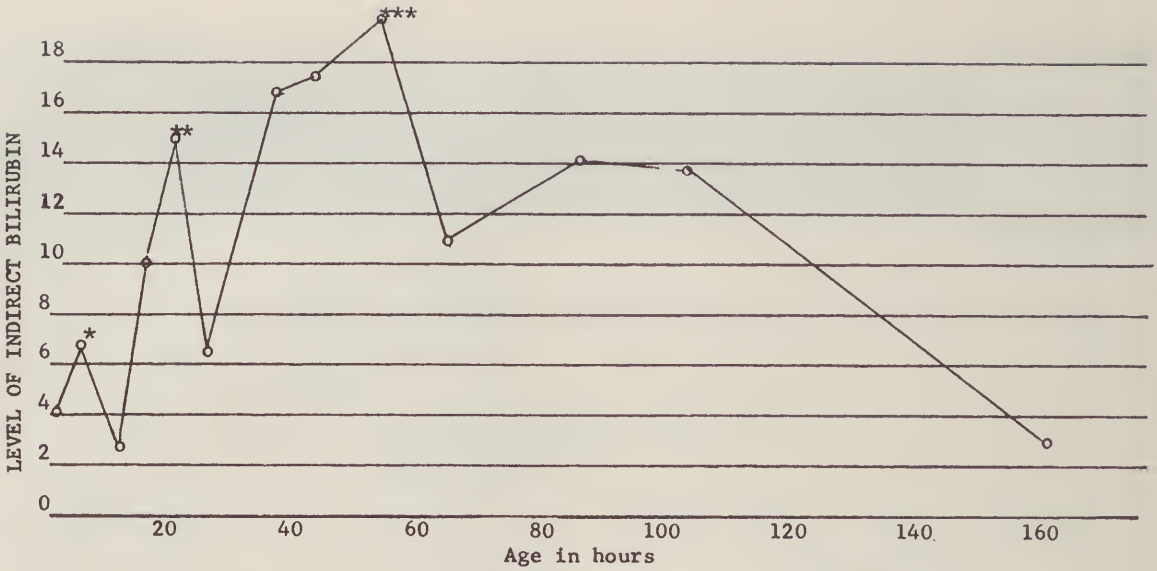


Figure 1

With this in mind the pregnancy was not allowed to progress beyond the 37th week of gestation at which time labor was induced.

Preparations had already been made at time of delivery for the infant to have an exchange transfusion. When the results of the Coombs test, the hemoglobin and bilirubin of the cord blood were reported, the exchange transfusion was carried out. The fact that this infant required two additional exchange transfusions attests to the severity of this disease process. It is indeed possible that if this infant had not been managed in such an efficient manner the outcome may not have been as favorable as it was.

Erythroblastosis Fetalis is a disease of the fetus and newborn infant characterized by a hemolytic anemia based on a blood group incompatibility between the mother and her offspring. The name Erythroblastosis Fetalis is derived from the appearance of nucleated red blood cells in the peripheral blood resulting from active proliferation of hematopoitic tissue not only in the bone marrow but in such places as the liver, spleen and other tissues not usually associated with the production of blood. This is a compensatory mechanism to excessive hemolysis. This incompatibility may occur in the ABO, Rh, or other rarer blood group systems.

The majority of the clinically significant cases result from incompatibilities arising in the Rh system. This may be regarded as associated with three linked pairs of genes; Cc, Dd, Ee. The designation Rh positive or Rh negative usually refers to the Dd system. Since the positive gene is dominant, the offspring of an Rh negative mother and a homozygous Rh positive father will always be Rh positive and hence a candidate for Erythroblastosis. On the other hand, only 50% of the offspring of an Rh negative mother and a heterozygous Rh positive father will be Rh positive.

The maternal Rh antibodies may be produced as a result of the mother having been previously transfused with blood that was incompatible in regard to the Rh system, or by leakage of fetal red cells into the maternal circulation. There is very good evidence that some leakage occurs in all pregnancies. This transplacental transfer is facilitated in man by the existence of a single cell layer separating the villi, containing the fetal capillaries, and the maternal blood sinuses.

Two conditions are prerequisite for the development of these maternal Rh antibodies; (1.) Fetal antigen must enter the maternal circulation and (2.) The mother must be capable of producing the agglutinins. The largest amount of fetal blood leaks into the maternal circulation at partuition; therefore, the firstborn Rh positive infant to an Rh negative mother is seldom affected with Erythroblastosis. In fact, only about 5% of all cases of Erythroblastosis due to Rh incompatibility occur in the first-born Rh positive offspring. In the majority of cases involving this 5% the mother has pre-

viously received a blood transfusion or has had a previous miscarriage. Thus the first Rh positive pregnancy of an Rh negative female serves to sensitize her to the Rh antigen and subsequent pregnancies act as booster stimuli to produce higher titres of antibody and as a result increased difficulty for the incompatible fetus.

It has been estimated that after primary sensitization the amount of blood required to produce significant antibody titres is very small, in the range of 0.03 - 0.07 ml.

There are several factors that affect the antibody titre produced by the mother. Some Rh negative females have several Rh positive infants that experience no difficulty with Erythroblastosis. These women seem to be incapable of producing significant antibody titres. It has also been demonstrated that if the fetus is incompatible both in the Rh and ABO systems, the production of maternal Rh antibodies will be reduced by the rapid destruction of the fetal red cells as they leak into the maternal circulation as a result of the ABO incompatibility. Thus, statistically at least, the Rh positive offspring of a couple who are incompatible in both the Rh and ABO systems will be less severely affected with Erythroblastosis than if only the Rh incompatibility existed.

Dr. Little—The rate of occurrence in the United States of clinically recognized Erythroblastosis due to Rh is about 1 in 200 births. If one considers that the percentage of marriages involving Rh negative females and Rh positive males is about 12%, one would expect the incidence of Erythroblastosis to be much higher. There are three factors that tend to keep the occurrence rate down: (1.) The tendency in the United States to small families; (2.) The fact that most men are heterozygous rather than homozygous, and (3.) As has been mentioned above, if both an Rh and ABO incompatibility exist, the severity of the Erythroblastosis due to Rh will be reduced.

Perhaps the single most helpful piece of information in making the diagnosis of Erythroblastosis Fetalis is the history of a previous sibling having had Erythroblastosis. Naturally, the knowledge that the mother of a jaundiced infant is Rh negative should make one immediately suspicious that he is dealing with Hemolytic disease of the newborn due to Rh incompatibility.

It is usually not difficult to substantiate this suspicion. In 1945 Coombs, et. al., reported that serum from rabbits immunized with human globulin would agglutinate human erythrocytes coated with anti Rh antibodies. This has come to be called the direct Coombs test and is, as a rule, positive in Erythroblastosis due to Rh incompatibility.

The management of patients for the purpose of diagnosis of Rh incompatability should include:

1. The Rh of all pregnant women should be determined as early in the pregnancy as she presents herself for medical care.
2. If the Rh of the mother is negative, the Rh and genotype of the father should then be determined.
3. If the father is Rh positive, the maternal antibody titre should be determined, preferably four times during the pregnancy. The last two times should be done during the last month to detect a sudden rise at or near term.

Naturally these laboratory determinations cannot supplant the clinical history in regard to previous pregnancies, blood transfusions and miscarriages that may have served to sensitize the mother.

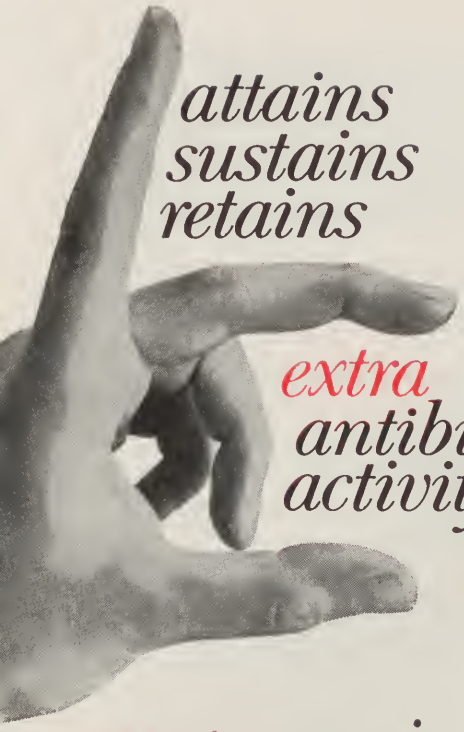
Dr. Allen—Once the diagnosis of Erythroblastosis has been made, the management of the patient is relatively simple. Therapy is directed at:

1. The prevention of, or control of, cardiac failure—the major cause of death in the first 24 hours.
2. The prevention or control of hyperbilirubinemia and resulting kernicterus—the major cause of death after the first 48 hours.
3. The control of anemia.

These complications are usually readily controlled by exchange transfusion.

In most cases the principal concern of the physician will be the control of hyperbilirubinemia in an effort to prevent kernicterus. There is no absolute level of indirect reacting bilirubin at which kernicterus will develop. However, the usual level that is considered critical is 20 mgm./100 ml., and the efforts of the physician are directed at an attempt to keep the serum bilirubin below this point.

Prematurity seems definitely to increase the infants' susceptibility to brain damage due to high bilirubin concentrations. Sulfisoxizole, as



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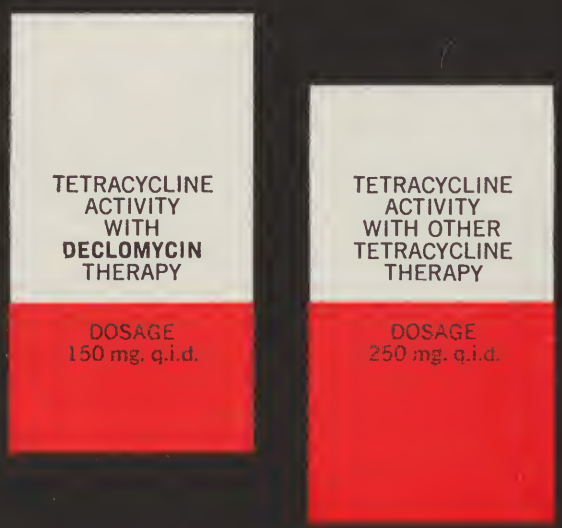
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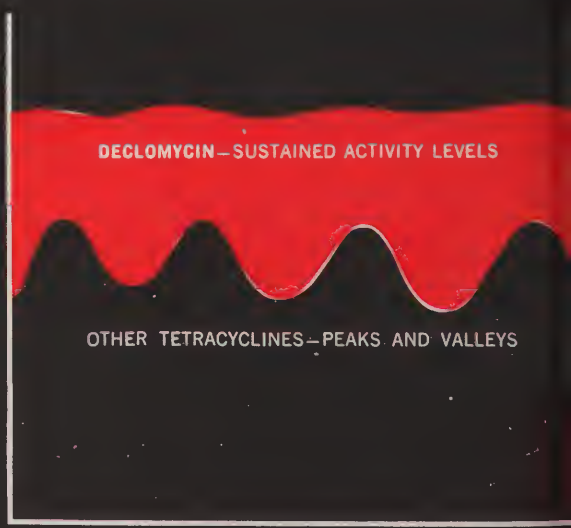
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POSITIVE ANTIBACTERIAL ACTION



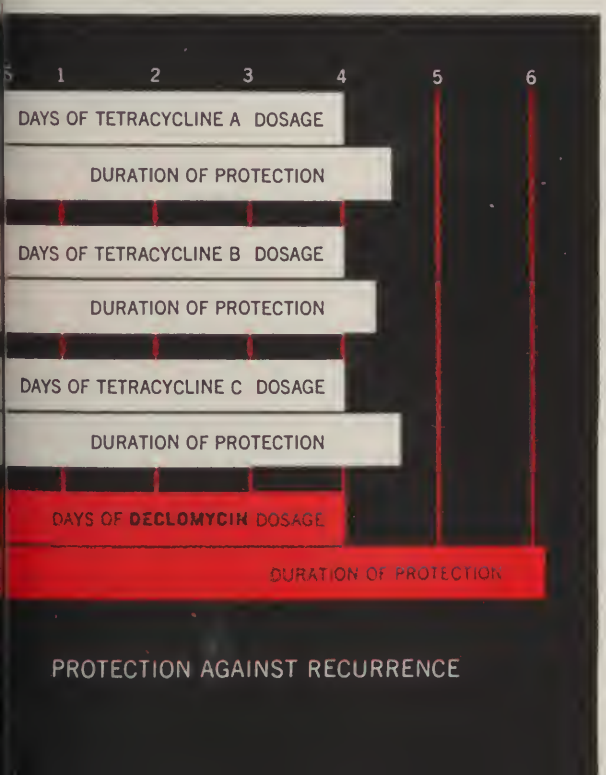
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PEDIATRIC DROPS, 60 mg./cc. in 10 cc. bottle with calibrated, plastic dropper. **Dosage:** 1 to 2 drops (3 to 6 mg.) per pound body weight per day—divided into 4 doses.

SYRUP, 75 mg./5 cc. teaspoonful (cherry-flavored), bottles of 2 and 16 fl. oz. **Dosage:** 3 to 6 mg. per pound body weight per day—divided into 4 doses.

PRECAUTIONS—As with other antibiotics, DECLOMYCIN may occasionally give rise to glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis or dermatitis. A photodynamic reaction to sunlight has been observed in a few patients on DECLOMYCIN. Although reversible by discontinuing therapy, patients should avoid exposure to intense sunlight. If adverse reaction or idiosyncrasy occurs, discontinue medication.

Overgrowth of nonsusceptible organisms is a possibility with DECLOMYCIN, as with other antibiotics. The patient should be kept under constant observation.

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well as high doses of vitamin K, has also been incriminated in inducing kernicterus. Of the infants that do develop kernicterus some 70% will succumb within the first week or so of life. The remaining 30% survive and make up about 10% of the population with cerebral palsy.

Exchange transfusion accomplishes four important things:

1, The removal of most of the serum bilirubin but very little of the bilirubin distributed in the extravascular spaces. Thus, shortly after the exchange transfusion one can expect the bilirubin to have returned to about 2/3 of its pre-exchange level.
2. The removal of most of the sensitized fetal erythrocytes that are candidates for hemolysis and their replacement with non-sensitizable erythrocytes. A two volume exchange transfusion that utilizes twice the infant's blood volume in donor blood to accomplish the exehange will result in the removal of 85-90% of the sensitized red cells.
3. The control of anemia and eorreetion of blood volume to control cardiac failure.
4. The removal of some of the circulating anti Rh antibody. This is not nearly as important as the first three since a large portion of the antibody is distributed in the extravascular spaces.

Exchange transfusion, although a relatively simple procedure, is not free from danger. The principal complications of exchange transfusion can be classified as follows:

CARDIOVASCULAR. As a safeguard against overloading the circulation, we generally recommend that one establish a negative balance of 10-20 ml. at the beginning of the exchange and correet this toward the end if the condition of the infant permits. Following the venous pressure at frequent intervals during the proeedure provides another check to prevent overloading the circulation. The pressure in the umbilical vein usually is about 3-4 centimeters of blood. It should never be allowed to rise to a level of 10 cm. or more. If this should occur, blood should be withdrawn until the pressure is reduced before the exchange is continued.

CITRATE INTOXICATION. The use of citrated blood in carrying out an exchange transfusion means that one is introducing a relatively large amount of citrate into the fetal circulation. This citrate will bind free calcium ions, thus producing an effective hypocalcemia and making the infant susceptible to tetany or even cardiae arrest. This condition can be easily prevented by the administration of ealcium during the proeedure. Usually 1-2 ml. of 10% calcium glueonate for each 100 ml. of citrated blood given will be adequate. It should be eautioned that this solution must be given slowly with someone listening to the infant's heart for slowing of the rate which may lead to cardiac arrest.

POTASSIUM INTOXICATION. We reeommend that one should never use blood for an exchange transfusion that is older than four days, and indeed it is preferable if the blood is less than 24 hours of age. Levels of potassium of 40 mgm. % or more have been noted in blood stored over 4 days. Thus, using blood over four days old may induee a marked hyperkalemia. There have been infants reported that have died during exchange transfusion where this was the only explanation that eould be found for the death. Blood stored for less than four days does not seem to earry this risk.

INFECTION. This should not be a problem in exchange transfusions if the same aseptic techniques are employed as for any other surgical procedure. The practice of leaving the catheter in place is to be deplored as it leaves the path open for the entry of infection.

Dr. Steigman—There has been mueh progress made in the diagnosis and treatment of Erythroblastosis due to Rh ineompatibility during the last half century to a point where the survival rate of all live births with Erythroblastosis due to Rh incompatibility is about 95%. With the recent discovery of the role of the glucuronyl transferase system in the metabolism and excretion of bilirubin the road has been opened to the finding of better ways to treat this disease and eventually to the discovery of a means of preventing it. Until this goal is reached we must concentrate our efforts toward the early recognition and prompt treatment of this disease. It is well to stress again that an antepartum suspicion that a fetus may be born with Erythroblastosis is always helpful in diagnosing and treating this disease and in severe eases may mean the difference between survival and death.

SPECIAL ARTICLES

Report On White House Conference On Aging

DWIGHT D. EISENHOWER, President of the United States, addressed the first White House Conference on Aging at the opening plenary session on January 9, 1961. This Conference was authorized by public law 85-908, September of 1958, and the underlying purpose was to have studied the findings and recommendations of the states and territories as a basis to spell out virtually all the needs and problems of the 50 million Americans who are 45 years and older, especially in the fields of health, income, employment, housing, family life and free time activities.

Immediately upon arrival in Washington, one discovered that the main theme or main area of discussion would concern the controversial legislative proposal on the tying of medical care for the aged into Title II of the Social Security program. This was sparked by headlines in the Providence, R.I., newspaper, which said that Aime Forand, a Democrat from New Jersey, was boycotting the Conference, inasmuch as he had not been invited. Mr. Forand will be remembered as the author of HR #4700, which was one of the main battles in the 86th session of the Congress in trying to place medical care for the aged under Social Security.

Rigging By AMA Charged

Word was also out in Washington that Wilbur J. Cohen, professor of Public Welfare Administration, School of Social Work at the University of Michigan, was boycotting the Conference. He claimed it had been rigged by the AMA and other groups in overloading the discussion groups with physicians and others who were opposed to putting the health care of the aged under Social Security.

Senator Pat McNamara from Michigan, at the first plenary session, early dispelled any thinking that this Conference was going to be an easy task for medicine or that it was going to receive much of a break. Senator McNamara charged that, from what he had seen of the past AMA propaganda campaign, it was evident that these same resources would be present at this Conference, and that apparently one tactic of the campaign was the placement of AMA orientated delegates in sufficient strength in certain work groups to give the nation the impression that the Conference did not favor such medical insurance under Social Security for the aged.

Senator McNamara went even further and said that, according to a breakdown of a vailable figures, 92 per cent of the doctors and dentists in Group One of the Conference had been assigned to the work group on financing medical costs. He pointed out that in these work groups one out of every three delegates represented the medical, dental or insurance professions. The American Medical Association was blasted by Senator McNamara, who said it was unfortunate that the AMA continues to devote such massive effort to the promotion of its 19th Century philosophy rather than concentrating on the needs of today and tomorrow.

First of all, to understand the workings of the Conference, it was necessary to know that some 2,700 delegates were registered and these would be broken down into 10 groups. From the group level we would go down to the section level, and there were 20 sections. Each of these 20 sections was to meet and adopt recommendations in its particular assigned field and then report its findings in summary form, containing no more than 1,200 words, at the final plenary sessions of the Conference on Wednesday night, January 11, and also Thursday morning, January 12. There was one additional breakdown of the sections into work groups composed of 20 to 30 persons. Actually, there were 133 work groups reporting to their respective 20 section chairmen.

280 Physicians Present

In examining Senator McNamara's statement that 92 per cent of the physicians and dentists in Group One had been assigned to work groups on financing medical costs, we find that by actual count (by the newspapers) only 280 physicians out of a total of 2,700 were in attendance at the Conference and, by the newspapers' own survey, only 36 per cent of this total were registered for the income and maintenance section, while it is assumed that the other 180 were primarily attending the health and medical care section.

The Washington newspapers carried the story that out of the approximately 280 physicians in attendance, 180 were registered in the health and welfare section and the remaining 100 were in the income maintenance section. However, one has to look at this figure to realize that this includes some doctors

who were definitely in opposition to organized medicine's views.

According to the ruling by the chairman, Mr. Robert W. Kean, who is a former United States Representative from the state of New Jersey, none of the 20 sections would have any jurisdiction on the financing of medical care costs outside of the income maintenance and employment section. This pointed out very vividly what an important role this particular section was going to play in the Conference, inasmuch as the final vote arrived at by the section as a whole, which altogether was composed of 28 work groups, would be the official statement of the White House Conference on Aging concerning the financing of medical care costs. There was to be no voting in the plenary sessions, and the 20 section chairmen would merely report to the plenary session which would give the group as a whole the thinking and recommendations of these various 20 sections.

Already, by the newspaper reporters' own figures, we have dispelled allegations that the American Medical Association had assigned 92 per cent of the doctors and dentists in attendance to Group One of the Conference, so I think it might be wise if we examined the section that had to do with the financing of medical costs. Actually there were seven work groups which were assigned to discuss findings of this section.

35 Persons In Work Groups

First of all, the over-all chairman of section Number 2 (income maintenance, including financing of health costs) was Charles I. Schottland, who is presently Dean of the Florence Heller Graduate School for Advanced Studies in Social Welfare at Brandeis University. He is the past president of the National Social Welfare, former Commissioner of Social Security, Department of Health, Department of Education, Department of Welfare, and former director of the California Department of Social Welfare.

Getting into the work groups and being particularly concerned with the seven groups that would make recommendations on the question of financing medical costs for the aged, we found that each work group had a chairman, a discussion leader, a recorder and two resource persons. This made 35 persons serving in this capacity in each of the seven work groups.

As a matter of interest, listed below are the organizations and the number of individuals from each group which composed these 35 delegates:

National Charitable Organization	1
Social workers	7
Labor	8
Political Science	1
Government-HEW-Social Security Employees and Public Welfare Employees	10
Physicians	1
Insurance Industry	3
Hospitals	1
American Nurses Association	1
Unknown	2
Total	35

It is very evident that organized medicine made no headway or had physician leadership in any of the seven work groups. The members of this committee were not ordinary laborers or social workers—they were people with high positions in their various organizations such as AFL-CIO legislative representatives, director of older and retired workers department, deans of schools of social work, chiefs and assistant chiefs of various departments of HEW.

These work groups met on Monday afternoon, Tuesday morning and also Tuesday afternoon to formulate their reports to their over-all section. By a combined vote of 96 to 77, the membership of these seven separate work groups specifically assigned to discuss the financing of medical care approved the Social Security method of providing medical care for the aged. These work groups also recommended the wider use of voluntary health plans and strong state implementation of medical care legislation passed by Congress last summer in the form of the Kerr-Mills bill.

At the main section meeting, the delegates adopted a comprehensive statement favoring the plan financed through Social Security by a vote of 170 to 99. This recommendation read as follows:

> "It is the recommendation of the majority that to ensure adequate health care for the aged with certainty and dignity, there should be established a basic program for financing health care for the aged within the framework of the Old Aged Survivors and Disability Insurance system."

The policy statement accompanying the recommendation included the assertion that the Social Security mechanism should be the basic means of financing health care for the aged.

Minority Report Permitted

According to the bylaws of the Conference, and because more than a third of those voting were against this recommendation, the minority group was allowed to file a minority report which was read in full to the delegates at the plenary session.

An interesting sidelight developed when the section on health and medical care voted 165 to 122 that health care under the Social Security mechanism is unnecessary and undesirable, that the implementation of such programs would not result in the high quality of medical care desired and that compulsory health care would inevitably result in poor quality medical care. This section had originally had a line reading, "We therefore feel that health care under the Social Security mechanism is unnecessary and undesirable."

Robert W. Kean, chairman of the Conference's National Advisory Committee, then informed Leonard W. Larson, M.D., chairman of the health and welfare section, that any reference to the discussion of the financing of medical care would have to be deleted inasmuch as rules set up some time ago had prohibited any session from discussing ways to finance medical care outside of the income maintenance section. The health and medical care section report then read as follows:

"Existing federal-state matching programs will provide effective, economical, dignified medical care

for elder citizens who need help. The implementation of such a program should result in the high quality of medical care desired. Compulsory health care inevitably results in poor quality health care."

The minority in this section were also allowed to file a minority report inasmuch as they had a third of the delegates voting and this was so entered on the record as a minority report, the same as in the section on the financing of medical costs.

By adhering to the rules of Chairman Kean, the health and medical care section was then unable to use the sentence that specifically condemned the Social Security approach, since it had to be deleted. At the final plenary session on Thursday, January 12, the delegates were again to get into an uproar as Section 20, which had to deal with federal organization programs, recommended that it was necessary and appropriate and a desirable responsibility of the Federal Government to finance health care benefits for the aged through a contributory system of Social Insurance (OASDI).

Reports In Written Form

As it was noted earlier in this report, there was to be no actual voting in the plenary session, and these reports were presented to the delegates in a written form and then read by the chairman of each section. The chairman of Section 20 read his report and then another report was read by another chairman of another section.

One of the delegates sent a note to Chairman Kean charging inconsistency in allowing mention of health care for the aged through a contributory system of social insurance, because of his prior ruling that the section on health and medical care could make no mention of financing by the Social Security system. The chairman then ruled that the delegate was out of order as he had allowed another report to be read before he officially voiced his opposition and it was therefore the ruling of the chair that Section No. 20 would stand as read and that the reference to the Social Security provisions would stay in the report as read to the delegates. An unsuccessful attempt was made by some of the delegates to have further discussion on this matter.

At the White House Conference on Aging it appeared that once again the venerable benefactor—Uncle Sam—is appearing as the great hope to many of the delegates who voted on hundreds of recommendations. The Conference heard speaker after speaker describe the majority of America's aged as poor, ill housed, lacking in proper medical care and rejected by society as a whole. Solutions have varied but most sections agreed that Uncle Sam was needed.

Some of the recommendations presented at this Conference appealing for federal help to ease the plight of the aged are as follows:

1. It is imperative that an institute of aging within the framework of the National Institute of Health be formed.

2. The section on housing urged the Federal Government to expand and liberalize federal mortgage insurance and long term loans; organize and conduct board housing research programs; and expand and extend the public housing program for the elderly.

3. Congressional appropriations of one hundred million dollars yearly or a direct loan program to the elderly for housing under the Administration of the Housing and Home Finance Aging.

4. Congress was asked to amend the Social Security Act to provide federal funds for general welfare cases which has been long sought by social workers.

5. The government was urged to give a sort of point 4 aid to states in the form of technical assistance in the setting up of aged programs.

6. That state and national commissions on aging be established, and that consideration be given by the Federal Government to the establishment and increase of grants and aids to states to promote and expand services to the aged.

Time alone will determine whether this White House Conference on Aging has contributed anything of value to this subject. But perhaps it has served as a mechanism to call more fully to the attention of the nation the responsibility of the state, the local community and the individual in establishing a better life for our senior citizens.

Emotional Charges Refuted

Surely the proceedings did refute the emotional charges that the doctors and organized business, insurance industry and others had captured the Conference. For the group of delegates that considered the financing of medical care costs did vote by a tally of 170 to 99 to urge Congress to establish provisions for handling the health care costs of the aged through a compulsory health insurance deductible plan under Social Security.

Certainly this Conference, from my point of view and the physicians from Kentucky who attended, was most enlightening. We can readily see that this question of medical care for the aged is certainly going to be with us for some time to come. Perhaps this was just the preliminary bout, as the main course is going to start the day Mr. Kennedy sends his proposal to Capitol Hill for enactment.

How can we be sure that medical care for the aged is going to continue to be such an important issue? According to an electric computing device which was on exhibit at the Conference, there is one person becoming 65 years of age each time the clock tallies 101 seconds. Carrying this mathmetical process through for a 24-hour period, we see that the population in the United States of those over 65 is increasing daily by 855 persons.

William E. Rudd, Secretary
Kentucky Medical Delegation to White House Conference on Aging

EDITORIALS

It Is Up To Us

GENERAL ALFRED M. GRUENTHER was the distinguished guest speaker at the annual convocation of the Louisville Chamber of Commerce on New Year's Day. From his long period of presidency of the American Red Cross, he has acquired a broad knowledge and active interest in medical affairs and in his address he said some things that are of general and specific interest to physicians.

During the fall of 1960, General Gruenther was in Russia representing the American Red Cross and making a study of the operation of Red Cross in other countries. He explained that the emblem used—the red cross on a white background—was adopted at the organization of the International Society in Switzerland and is adapted from the Swiss flag which has a white cross and red background. With the organization of the Society in Moslem countries the red cross emblem was not used because it might be confused as a religious symbol. In its place was adopted a red crescent on a white background. Of the national organizations in this field, numbering about 85, there are 12 using the red crescent emblem. Of the 12 such organizations in the Soviet Union, nine use the red cross and three the red crescent.

The Russian Organization concerns itself entirely with strictly medical problems. The gathering and distribution of blood for transfusions is managed by the state. Likewise, help provided in disaster areas is given by the state and is not a concern of the Red Cross.

More than half the countries of the world, comprising much more than half the entire population, are on a standard of living which by our measurement would be regarded as a poverty or hunger level. The conflict in ideology between communism and capitalism will largely be decided by the attitudes of these two systems toward the substandard areas of the world. At the present time we are not distinguishing ourselves in the esteem of the hungry nations of the world by any record of marked superiority in this conflict of ideology.

The Soviet Union with a population of 280,000,000 people has 320,000 physicians, 70 per cent of whom are women. The United States with a population of 186,000,000 has 240,000 physicians, less than 10 per cent of whom are women. We are producing young physicians at the rate of 7,000 annually, having attained that number only in the past two years. The Soviet Union has been graduating about 16,000 physicians a year during the past four years. We are, of course, not necessarily concerned in such a comparison of numbers except it points up the fact that by this single standard American authorities are generally right in their insistence that our supply of physicians must be rapidly increased to a level of 11,000 a year, if we are to meet the demand of adequate medical service with a sufficient number of physicians.

The United States is not about to yield superiority to the Soviet Union either economically, militarily, or psychologically. In General Gruenther's opinion, we enjoy a wide margin of advantage in each of these fields at the present time; however, the margin of advantage is less psychologically than it is in either of the other two fields. He does not believe that a war is imminent, but he believes that the conflict in ideologies and the contest for balance of world power will continue at its present or increased tempo. He expressed a personal feeling of optimism that the advantage is decidedly

with the United States at the present time and will continue so indefinitely, but not without our intelligent and united effort and sacrifice.

He suggests that we as a nation must do more than we have ever done in learning about the people, their civilization and their peculiar cultures. We are especially deficient in learning and using the languages of other countries and thereby fail to develop adequate useful communication with them. We must learn to give more freely of service to our country and to our individual communities.

The image of the United States in the eyes of the world needs vast improvement. It is up to us.

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A NEW ADMINISTRATION has taken over the affairs of government in Washington. The next four years are almost certain to be unusually eventful ones, but no one can quite foresee what new or different trend of events and policies may occur. We genuinely hope that time will prove that the choice of the electorate was a wise one, and that the affairs of this country and of all mankind will improve rather than worsen under the direction of our new leaders.

It is very probable that the ideologies and philosophy of government of the two major parties actually differed to no greater degree than did the margin by which the present administration was elected. Anyone who read carefully or listened intently to the televised discussion of the two candidates must have felt that there was little actual difference in the objectives desired, although there appeared to be a considerable difference in the means by which these objectives could best be achieved.

In matters affecting the medical profession and medical care, there appeared to be as wide a divergence of opinion as in any other major field. The medical profession generally supported the losing candidate because it was felt that his philosophy toward private enterprise and toward medical care was more practical and best suited our own ideals; but, after all, it has been repeatedly demonstrated that the Congress more than the executive branch of government is likely to determine the trend which this country is to follow in that respect.

Twenty-five years ago and thereabouts the threat of complete government control of medical care was thwarted. Since that time there have been numerous small and large encroachments by the government upon the conduct of medical care in the hands of physicians. We can reasonably expect that the present administration will attempt to effect, through administration of the affairs of the aged, a greater single encroachment upon medical practice by the government than has yet been accomplished in a similar period of time.

We have learned from the experience of the past 25 years that the voice and preference of the medical profession and its constituency is heard with respect by our Representatives in Washington and that the trend of legislation has been significantly influenced thereby. The passage of the Mills Bill in the last Congress seemed a reasonable and rational approach to the problem of medical care for the aging, and the very fact that this moderate measure was written into law instead of the more extensive one advocated by some gave us great encouragement.

We cannot afford to do less than to continue with increased effort as individual citizens and as a profession to oppose extensive government control of medical care.

The long heralded White House Conference on the care of the aging has been held and whatever information or misinformation that conference produced will now have its effect on the legislation of the immediate future. As a profession we do not wish to be reactionary, nor necessarily to be labeled conservative, but we will continue to work for the preservation of free enterprise and in opposition to government control of medical care in the firm belief that this course is the best path for the United States in the present age.

Sam A. Overstreet, M.D.

ORGANIZATION SECTION

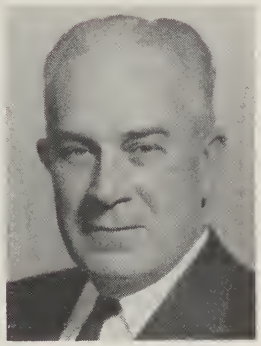
Plans For Officers Conference April 6 Are Complete

Plans for the 11th annual County Society Officers Conference, to be held Thursday, April 6, in the Phoenix Hotel in Lexington, are now complete, Richard G. Elliott, M.D., KSMA president, has announced.

Congressman John C. Watts of Nicholasville, who represents the Sixth Congressional District in Kentucky and who is a member of the House Ways and Means Committee, will be the luncheon speaker, Doctor Elliott said. The general subject matter to be considered by Mr. Watts will be in the area of physician responsibility in national affairs.



Mr. Watts



Dr. Welch

Norman Welch, M.D., Boston, Mass., immediate past-president of the National Blue Shield Commission, will be one of the three morning speakers. Doctor Welch is also Speaker of the House of the American Medical Association.

Completing the lineup for the morning session will be Raymond M. McKeown, M.D., Coos Bay, Ore., chairman of the AMA's Committee on Medical Disciplinary Matters and also a member of the AMA Board of Trustees, along with Leo Brown, Chicago, director of the AMA's Division of Communications.

Featured speaker of the afternoon session will be Roger Fleming, head of the American Farm Bureau Federation Washington office and secretary of that organization. He is a very much sought-after speaker. Joe Miller, former Kentuckian and a member of the AMA's field staff, will also speak briefly in the afternoon session.

The complete program will appear in the March issue of The Journal.

Will Your Officers be Invited?

If you're one of the county society secretaries who has not yet forwarded his listings of new officers and committeemen to the Headquarters Office, you are requested to do so at your earliest possible convenience.

The importance of getting the names in promptly was stressed by Richard G. Elliott, M.D., KSMA president, who said he was making this urgent request so that these new officers and committee members might receive invitations to the County Society Officers Conference in Lexington on April 6.

FDA Amends New Regulations On Labeling Of Drugs

The Food and Drug Administration has amended its new regulations requiring changes in labeling used to promote the sale of prescription drugs to physicians. At the same time the agency extended to February 7, 1961, the effective date of those parts of the regulations previously scheduled to become effective on January 8, 1961. These regulations were published in the Federal Register on December 9, 1960.

Time extensions also have been granted for compliance with certain parts of the regulations scheduled to have become effective on March 9, 1961.

As amended, the regulations will extend the March 9, 1961, date and make these other changes:

1. Permit the use until January 1, 1962, of labels already printed even though they do not contain all the information required in the order published in the Federal Register on December 9, 1960, if the information is elsewhere on the package or in a brochure enclosed in that package.

2. Permit until June 6, 1961, the marketing of drugs already packaged without code or control number on the carton if this number is on the label.

3. Provide for continued use until January 1, 1962, of catalogs and price lists which have some information (but not full disclosure) if sent only to pharmacists and wholesale druggists, and not to medical practitioners.

The regulations also were amended to make it clear that no package insert is required solely because the label bears the dosage information called for in another section. John L. Harvey, Deputy Commissioner of Food and Drugs, said that the basic question as to required package inserts is being considered in the light of all comments submitted in response to an earlier proposal published in the Federal Register July 22, 1960. Time for submitted comments expired December 22, 1960.



Dr. Katz



Dr. Page

Seventh Heart Symposium Set March 22-23 In Louisville

The Heart Association of Louisville and Jefferson County and the University of Louisville School of Medicine have announced the program for their Seventh Annual Symposium on Cardiovascular Disease, March 22 and 23, at the Brown Hotel, Louisville. Twelve U.S. medical authorities will be joined by one from Canada as guest speakers for the two-day event.

A feature of the program will be a dinner on March 22, addressed by Irvin H. Page, M.D., Cleveland, Ohio, director of research for the Cleveland Clinic Foundation since 1945. He will talk on "My Life and Hard Times As a Cardiologist." The dinner is open to the public.

Doctor Page is a past president of the American Society for the Study of Arteriosclerosis and of the American Heart Association. A member of the Council for the Advancement of Science Writing, he received the Ida B. Gould Memorial Award of the American Association for Advancement of Science in 1957 and the Albert Lasker Award in 1958. He is editor-in-chief of *Modern Science*.

One of the prominent essayists booked for the March 23 program is Louis N. Katz, M.D., Chicago, director of the Cardiovascular Department, Medical Research Institute, Michael Reese Hospital, and professorial lecturer in physiology at the University of Chicago. A native of Poland, Doctor Reese came to this country in 1900 and received his medical education at Western Reserve University. He is the author of a number of medical books and pamphlets, holds a long list of appointments by medical, scientific, educational and public institutions, and is a member of more than 25 medical groups.

Jack L. Chumley, M.D., Louisville, scientific editor of *The Journal* of KSMA, is chairman of the program committee for the symposium, which also includes Robert L. McClendon, M.D., president of the Heart Association of Louisville and Jefferson County, and Walter S. Coe, M.D., Louisville. The course has been submitted for AAGP Category One credit.

For the complete program, turn to Page 191 of this issue of The Journal.

Polio Immunization Program Stepped Up In State

More than $30,000 of Salk polio vaccine was made available to the 120 county health departments in Kentucky during the first week in January, the Division of Local Health, State Department of Health, has announced.

The county boards of health, in cooperation with the local physicians, are setting up local polio immunization programs over the state in an effort to raise the level of immunization against the disease. Surveys throughout the state show a low level of immunization, particularly in persons over 15.

The need for a vigorous immunization program in Kentucky is pointed up by the increased incidence of polio. Last year there were 165 cases—an increase of 52 cases or 31.5 per cent over the previous year. These figures are particularly significant when compared to those of the United States as a whole, which showed 3,071 cases in 1960—a reduction of 5,506 cases, or 179 per cent fewer cases.

The Salk polio vaccine for the counties is being supplied on a proportionate basis, the Health Department said. The nine-dose vials of vaccine available are sufficient for 350,000 individual shots.

Medicare Pays Kentucky Physicians $283,929 For Year 1960

Kentucky physicians received $283,929 under the Medicare program for 1960, according to figures released by Blue Shield-Blue Cross. Blue Shield is the fiscal agent for the Kentucky State Medical Association in processing claims under the program, while Blue Cross operates in a similar capacity for the Kentucky Hospital Association.

The Medicare program is a contract between the KSMA and the U.S. Government whereby Kentucky physicians provide medical services to dependents of the Armed Forces on a fixed fee basis. The dependents are wives and children of servicemen and must be certified by the government as such before the program provides medical services.

A breakdown of payments to Kentucky physicians in 1960 follows:

	Cases	Amount Paid
Maternity	1248	$157,248.00
Medical & Surgical (In Hospital)	1593	104,604.00
Medical & Surgical (Out of Hospital)	224	5,935.00
Anaesthesia	606	13,825.00
Consultant	49	1,054.00
Surgical Assistants	38	969.00
Miscellaneous (Out of Hospital)	12	294.00
Total	3770	$283,929.00

Medicare payments to hospitals for the year 1960 totaled $314,431.69.

905 M.D.'s Serving As Trustees Of Blue Shield Plans

Of the 1,330 trustees serving on the boards of directors of the 68 Blue Shield Plans in the United States, 905 are physicians, it was reported last month by the National Association of Blue Shield Plans, Chicago.

The board of directors of Kentucky Physicians Mutual, the Blue Shield Plan for Kentucky, is made up of 25 physicians and six laymen. Among the physicians, seven specialties are represented.

The report also revealed that, in the case of most all Plans, more than 50 per cent of the governing boards are composed of physicians.

"The active participation of physicians on Plans boards to the extent that they are represented," the association noted, "provides assurance that the Blue Shield Plans represent the doctor's own contribution to the development of a suitable mechanism to help people meet the cost of health care on a voluntary basis."

Film Of 1958 Medical Mission Project Scheduled On TV

"Operation: Brother's Keeper" is the title of a color film describing a medical mission survey project which took Gabe A. Payne, M.D., Hopkinsville, and five other U.S. physicians on a three-month journey through Asia and Africa in 1958. The film is scheduled to be shown on television stations east of the Mississippi River on March 19, according to the *AMA News*.

During the trip, the physicians administered 90,000 inoculations, distributed more than $100,000 worth of medical supplies, drugs and books, surveyed 100 hospitals, performed 120 operations, delivered 128 medical lectures to audiences of more than 5,500, and participated in 47 conferences with government and health leaders.

A resolution supporting such medical mission projects was passed by the AMA House of Delegates at the Clinical Meeting in Washington. The resolution approved a study to develop a mechanism by which AMA members may serve in the foreign mission fields on a temporary basis when emergencies arise and instructed that volunteer physicians to serve in such capacities be sought when the mechanism has been developed.

U. L. Wants Old Health Building For Medical-Research Center

The University of Louisville would like to acquire the old State Department of Health Building in Louisville for a new medical-research center and has applied for a federal grant of some $2,500,000 to set up and operate it.

These plans came to light January 7, after the State Property and Building Commission announced that it had agreed to put the building up for sale. A meeting of the bondholders to vote on the commission's proposal is scheduled for February 15 in the Governor's conference room. The structure is appraised at $400,000.

The U. of L. proposes to use the building as a research center for biotransport and membrane physics. Its application for the federal grant is pending before the Division of General Medical Sciences of the National Institutes of Health, Bethesda, Md.

Waverly May Become State Center For the Mentally Retarded

Waverly Hills Tuberculosis Sanatorium may be taken over by the State as a training center for mentally retarded children and adults. After a tour of the 400-bed institution on January 11, Governor Combs announced that a State survey team would be sent to study the hospital's adaptability for that purpose.

The State's only institution for the mentally retarded, Kentucky Training School at Frankfort, is badly overcrowded and has a waiting list.

Waverly Hills, scheduled to close July 1, is owned by the Louisville-Jefferson County Health Department, which hopes to get enough money from its sale to build a new office building in Central Louisville. Its tuberculosis patients are being transferred to State-owned Hazelwood Tuberculosis Sanatorium.

London Society Honors Mr. Ruskjer

S. A. Ruskjer, administrator of Waverly Hills Tuberculosis Sanatorium since 1955, has been named a fellow in the Royal Society of Health in London. He is the fifth hospital administrator in the United States to be so honored by the world's largest health organization.

Mr. Ruskjer, a member of the Kentucky Physicians Mutual Board of Directors, is a fellow and former vice-president of the American College of Hospital Administrators and president of its board of examiners. A member of the house of delegates of the American Hospital Association, he has served on committees for that group, the AMA and other health organizations.

Mrs. Caudill to Handle Licensures

Mrs. Edna Frank Caudill, Louisville, is the new director of the Division of Medical Licensure of the State Board of Health, Frankfort. She succeeded Mrs. Ray Wunderlich, who retired January 1 after 25 years in that post.

For the past 10 years, Mrs. Caudill was assistant secretary of the Kentucky Dental Association. Her husband, the late Fred W. Caudill, was epidemiologist with the State Board of Health.

Dr. Archer Heads Drive For College

George P. Archer, M.D., Prestonsburg, was named chairman of a committee appointed by the Prestonsburg Community Development Council to promote a state-operated junior college. Another physician, R. L. Hall, M.D., is a member of the committee.

Former Radio Star Is Speaker For Senior Day March 20

KSMA's annual Senior Day for senior medical students at the University of Louisville School of Medicine will be held early this year—on Monday, March 20, it is announced by Carl Cooper, M.D., chairman of the Senior Day Committee. Cosponsors of the event are the Jefferson County Medical Society and the medical school.



Mr. Lauck

The featured dinner speaker will be Chester Lauck, executive assistant of the Continental Oil Company, Houston, Texas, through whose courtesy he is making his Louisville appearance. Mr. Lauck will be remembered as "Lum" of the popular radio and movie team of "Lum and Abner." After 25 years in show business, he joined the oil firm and now travels more than 100,000 miles annually throughout its 27-state marketing area. In demand as a speaker, he has delivered as many as eight addresses in five different states within one week. His talk on March 20 will be on "Socialized Medicine."

The day's activities will follow the format of former years, opening at noon at Louisville General Hospital with an address by KSMA President Richard G. Elliott, M.D., Lexington. At 2:30 p.m., a program designed to help the students bridge the gap between medical classroom and actual practice will be presented at the Kentucky Hotel.

In the evening, the students will be guests of the Jefferson County Society at a social hour and dinner in the Terrace Room of the hotel. Daniel Costigan, M.D., president of the society, invites all KSMA members to attend.

A tea for wives and sweethearts of the medical students is planned for the afternoon by the Woman's Auxiliary to KSMA.

The complete Senior Day program will be announced in the March issue of The Journal.

PG Courses In Ob-Gyn Each Week At Louisville General

A six-day training course in the field of Ob-Gyn is being offered each week during 1961, with five exceptions, at Louisville General Hospital. Sponsors are the University of Louisville School of Medicine's Department of Obstetrics and Gynecology and the KSMA Postgraduate Medical Education Office, and the supervisor is Douglas M. Haynes, M.D., professor and chairman of the Department.

The postgraduate medical opportunity is limited to two physicians per week, with two-week advance enrollment requested. The registration fee of $50 includes a room at the hospital if desired. The course has been submitted for Category One Credit of the KAGP.

A typical day starts at 8 a.m. with a lecture and ends with "rotating night duty" from 5 p.m. to 8 a.m.

The five weeks during which the course will not be held are: April 17-22, April 24-29, May 15-20, October 2-7, and October 23-28.

Pediatrics PG Course Slated Apr. 4 - May 23 In Louisville

An eight-week postgraduate course in Pediatrics is scheduled to open April 4 at Children's Hospital, Louisville, and continue on consecutive Tuesdays through May 23. Sponsors are the Department of Pediatrics of the University of Louisville School of Medicine and the KSMA Postgraduate Medical Education Office.

The group will meet each Tuesday at 9:30 a.m. in the Children's Hospital amphitheatre. Then smaller sections will go on staff-conducted rounds of either that hospital or Louisville General Hospital. A case conference at 10:30 a.m. will be followed at 11:30 by a scientific presentation.

The faculty will be made up of seven instructors at the medical school: Walter S. Coe, M.D., associate professor of medicine and chairman of the KSMA Committee on Postgraduate Education; Frank Falkner, M.D., assistant professor of child health and pediatrics; Martin Z. Kaplan, M.D., instructor in pediatrics; Joseph A. Little, M.D., associate professor of pediatrics and physician-in-chief at Children's Hospital; Roderick J. Macdonald, M.D., assistant professor of ophthalmology and executive director, Section on Ophthalmology; Alex J. Steigman, M.D., professor of child health and chairman of the Department of Pediatrics, and Daniel Stevens, M.D., associate professor of pathology.

Subjects announced for the weekly programs are: April 4, "Immunization"; April 11, "Rehabilitation In Heart Disease In Children"; April 18, "Growth Problems—Clinical Application"; April 25, "Diagnostic Tools In Liver Disease"; May 2, "Dietary Deficiencies"; May 9, "Newer Concepts In Mental Retardation"; May 16, "Eye Problems Peculiar to Childhood"; May 23, "Question and Answer Period."

Registration fee for the course, which has been submitted for AAGP Category One Credit, is $30, or $5 per day.

Red Cross Volunteers Needed!

The American Red Cross has issued an urgent appeal for volunteers to serve in a wide variety of activities.

"We need blood center aides, motor service drivers, typists and canteen workers," said Mrs. Arthur D. Bickel, chairman of recruitment for the Louisville Chapter. She urges interested persons to call the Volunteer Office, ME 4-4711, for an appointment.

Miss Beem, U.L. Medical Librarian For 25 Years, Retires

Librarian at the University of Louisville School of Medicine since 1935, Miss Blake Beem retired February 1 after 40 years in medical library work.



Miss Beem

A native of Spencer, Ind., Miss Beem grew up in Little Rock Ark., where she began her career in January, 1921, as librarian at the University of Arkansas School of Medicine, a post she held eight years. From 1928 to 1932, she was relief librarian and assistant to the director of the Boston Medical Library. Returning to Little Rock, she was made librarian and case consultant in the Social Service Division of the Arkansas Relief Administration. She came to Louisville in 1935.

Miss Beem's successor at the Louisville Medical Library is Miss Joan Titley, formerly of the University of Cincinnati School of Medicine Library. She has been in Louisville since last November 15.

U. L. Medical-Dental Building Given Additional $82,939

A supplemental grant of $82,939 to the University of Louisville for its proposed new medical-dental research building has been announced by Leroy E. Burney, M.D., Surgeon General of the Public Health Service.

This brings to approximately $1,473,091 the total of federal funds awarded to the university for the project. The new building, to be erected in the Louisville Medical Center, will cost an estimated $2,946,-182.

The new grant was one of 26 Health Research Facilities awards, totaling $6,670,880, made to 24 institutions in 15 states, under a program administered by the Division of Research Grants of the National Institutes of Health. In its five years of existence, the program has awarded 756 grants, totaling $149,-991,729, to 321 institutions in 47 states, the District of Columbia and Puerto Rico. Funds are awarded on a matching basis to public and private nonprofit hospitals, medical and dental schools, schools of public health and other research institutions.

Health Unit Expands Field Services

Establishment of two new district offices at Paducah and Newport to direct field work for the Division of Occupational Health, State Department of Health, has been announced by Norman E. Schell, division director. This brings to three the total number of area offices, the first having been set up in Louisville last year. Additional district offices are planned when qualified hygienists can be located to staff them, Mr. Schell said. The decentralization of field work is intended to increase on-the-spot services to Kentucky's workers and industry.

Handicapped Children Unit To Establish Eye Clinic

The Commission for Handicapped Children, Louisville, has announced plans to unite with Children's Hospital in establishing a clinic to provide eye care for the needy children of Kentucky. The clinic, to be opened in the near future, will be staffed by the faculty of the University of Louisville School of Medicine, Department of Ophthalmology, as part of the hospital's teaching and treatment program.

Facilities will be available for examinations, muscle training, treatment of acute eye conditions, surgery as indicated and prostheses. It is expected that glasses will be purchased by the parents or by local agencies.

To be eligible for care, a child must meet the legal requirements of the Commission; that is, he must be amenable to treatment, his parents must be unable to afford part or all of the cost of treatment, and he must be under 21. Referrals should be sent to Children's Hospital, Eye Clinic, 226 East Chestnut Street, Louisville, or to the Commission for Handicapped Children, 1405 East Burnett, Louisville. Patients will be seen by appointment only. Notices of appointments will be mailed to parents.

The Commission has previously given a minimal amount of eye care to children treated under its other programs, but was unable to accept eye surgery per se. Children's Hospital had to close down its outpatient program for eye care about a year ago. By uniting the two facilities, it is expected that many children will be examined and that 250 to 300 will receive eye surgery within a year's time.

The clinic is not to compete with the eye clinic at Louisville General Hospital, a Commission spokesman said.

Shelby First to Pay 1961 Dues

The Shelby County Medical Society led all other societies in the state in paying KSMA and AMA membership dues for 1961. A check from the secretary, C. C. Risk, D.D.S., was the first remittance received in the KSMA Headquarters Office.

AMA Journal Expands News

The Journal of AMA, beginning February 4, presented a revised format for the Medical News Section. The plan is to include a wider coverage of regional news, physician honors and appointments, and other notes of interest, according to Charles F. Chapman, news editor. More photographs and/or sketches also will be used. Mr. Chapman urges that news briefs of activities of medical organizations and pictures be sent to him at 535 North Dearborn Street, Chicago, Illinois.

NEWS ITEMS

William Justin Cates, M.D., has opened an office in Cloverport for the general practice of medicine. He previously practiced at McDowell Miners' Memorial Hospital, McDowell. Doctor Cates, a native of Walden, N. Y., received his medical degree from Boston University in 1958, interned at Stamford Hospital, and took pathology training at the City of Kingston Laboratories, Kingston, N. Y.

John E. Cotthoff, M.D., who had practiced at Kuttawa since 1952, began a residency at St. Thomas Hospital, Nashville, the first of the year.

The Dr. J. W. Crook Memorial Arts and Craft House is the name selected for a new building planned for the Feltner 4-H Club Memorial Camp at Hazard. Funds for the structure, to be built this spring, were given by Mrs. Cook in memory of her late physician husband.

Harry C. Denham, M.D., Maysville, was elected a director of the State National Bank of Maysville at the bank's annual election in January. Another Maysville physician, **W. H. Cartmell, M.D.,** was renamed to the board of directors of the Bank of Maysville.

Melvin E. Meyer, M.D., is stationed on active duty at the U.S. Navy Recruiting Station in Ashland. A 1959 graduate of the Minnesota Medical School, he interned at St. Mary's Hospital, Minneapolis, after which he entered the service. Doctor Meyer is a native of LeSueur, Minn.

Richard E. Mudd, M.D., has opened an office at 2221 Meadow Drive, Louisville, after practicing in Lebanon, Tenn., for 12 years. Born in New Haven, Ky., Doctor Mudd received his M.D. degree from the University of Louisville School of Medicine in 1943, after which he interned at St. Elizabeth's Hospital and was a resident at Nichols VA Hospital. He served three years in the U.S. Army with the rank of captain.

B. N. Pittenger, M.D., Paris physician, has been elected president of the National Bank and Trust Company of Paris. He succeeds **J. C. Hart, M.D.,** who moved recently to Florida.

Jesse W. Page, M.D., has started practice in Mayfield in association with the Fuller-Morgan Clinic, after a year's practice at Poplar Bluff, Mo. His specialty is internal medicine and rheumatology. After earning his medical degree from Washington University in 1953, Doctor Page interned and took residency training at St. Louis County Hospital. In 1959-60 he was instructor in the Department of Internal Medicine at the University of Michigan and trainee in the Rackham Arthritis Research Unit. He served two years in the U.S. Air Force at its hospital in Victoria, Texas, attaining the rank of captain. Doctor Page is a native of Chaonia, Mo.

Earl Douglas Rees, M.D., a resident at the Ben May Laboratory for Cancer Research at the University of Chicago from 1958-60, has joined the faculty of the University of Kentucky Medical Center as assistant professor of medicine. A 1954 graduate of Yale University Medical School, Doctor Rees was a Postdoctoral Fellow of the National Foundation in protein chemistry at Yale the following year, after which he interned at Ohio State University Hospitals. He was a captain in the Medical Corps from 1956-58, with the Armed Forces Institute of Pathology (Biochemistry and Biophysics Sections). Doctor Rees is a native of Cleveland, Ohio.

E. T. Runyon, M.D., and Mrs. Runyon of Ewing recently celebrated their 60th wedding anniversary. A native of Fleming County, Doctor Runyon has practiced medicine half a century.

Stanley D. Wheeler, M.D., has started the practice of medicine in Onedia, in association with **Caleb Chu, M.D.,** and **John O. Ford, M.D.** A native of Los Angeles, Calif., Doctor Wheeler received his M.D. degree from the College of Medical Evangelism in 1947 and interned in Loma Linda, Calif. He practiced in California and a short time in Georgia before coming to Kentucky. He served two years in the U. S. Army, attaining the rank of captain.

Dr. Shields Honored At 80

Benjamin Fields Shields, M.D., Shelbyville, was honored on his 80th birthday January 2, when more than 300 persons gathered at the Shelbyville Christian Church for a testimonial program and reception. Judge Coleman Wright was the master of ceremonies, and speakers included former Governor A. B. Chandler, former Lieutenant Governor Harry Lee Waterfield and Donald Chatham, M.D.

Interested in good government, Doctor Shields was long a member of the Kentucky House of Representatives and retired as a State Senator in 1958. He was a delegate to the Democratic national convention in 1920, 1924, 1940, 1952, 1956 and 1960. A 1905 graduate of the old Hospital College of Medicine, Louisville, he began his medical career at Ashbrook. He later practiced at Salvisa, Little Mount and Taylorsville before moving to Shelbyville in 1945.

Dr. Seay Practicing 67th Year

E. V. Seay, M.D., of Salvisa, who is in his 67th year as a practicing physician, was featured in an article in the Lexington *Herald-Leader* January 8. He will be 90 years old in July. A native of Willisburg, Doctor Seay received his medical degree from the University of Louisville in 1893 and began his practice in Ashbrook. He moved to Salvisa in 1905. The Salvisa Christian Church honored him on his 89th birthday last July as its oldest member.

KSMA Council, Committee Reports

Council On Allied Professions and Related Groups

J. Farra VanMeter, M.D., Chairman

Brown Hotel, Louisville **January 5, 1961**

The first meeting of this Council was held in Louisville to formulate plans for the coming year and determine in what areas the Council could be of the most assistance to the committees assigned to it.

A general discussion was held on all the Council's committees regarding their functions in the past and also what the areas of future activity should be. There are seven committees under this Council: Dental-Nurse-Pharmacy; Infant and Maternal Mortality; Physical Medicine and Rehabilitation; Tuberculosis; Blood Banks; Industrial Medicine, and the KSMA Liaison Committee to Voluntary Health Groups.

It was felt that the future activity of the Council would somewhat be defined by the action of the committees under it and therefore all committees should be urged to explain fully their capabilities. Even for those committees that have not previously been active, it was suggested that they meet and have a general discussion on their field of activity.

Council on Legislative Activities

George Archer, M.D., Chairman

Brown Hotel, Louisville **December 8, 1960**

The Council on Legislative Activities held its first meeting under the new organizational setup of KSMA Councils and Committees on Thursday, December 8, at the Brown Hotel in Louisville.

Implementation of actions by the House of Delegates directed to this Council was discussed. These actions dealt with: Introducing legislation on compulsory vaccination; having two members from specialty groups named to review bills relating to their specialty; studying and improving weak spots in the Key Man System; having a Legislative Committee of the eight Congressional District Key Men under the Council on Legislative Activities; developing a Physicians League for Political Action separate and apart from KSMA; publicizing the fact that taxpayers with dependent parents 65 and older are authorized full deduction for medical expenses beginning with the taxable year 1960; continuing to have the Congressional Dinner for congressmen in Washington, and studying and making recommendations relative to the mail order drug business which is now being conducted in Kentucky.

The Council made recommendations on how the mandates could best be implemented and requested the KSMA Headquarters Staff to proceed accordingly. One of the major changes suggested to improve the Key Man System at the county level was to have the county medical societies select their key man for the county rather than have the sub-district key men name them in their respective counties, as they have in the past.

The request by the AMA House of Delegates that physicians at the local level take a more active part in public affairs, including politics, was felt could best be handled by Practical Politics Courses with county medical society members and their wives. KSMA's director of Field Services, with the assistance of the AMA Field Representative for Kentucky, will be responsible for initiating the Practical Politics Courses.

Council on Medical Education and Hospitals

Walter S. Coe, M.D., Chairman

Brown Hotel, Louisville **December 8, 1960**

The Council on Medical Education and Hospitals, meeting for the first time under the KSMA's new organizational setup, discussed its plans and goals for the associational year.

A general discussion was held on each of the six committees under the Council as to the general area with which each of these committees should concern itself during the year.

Action taken by the AMA House of Delegates on payments to clinical physicians at medical schools, the AMA national scholarship program, and the ECFMG program were discussed by the Council.

Senior Day Committee

Carl S. Cooper, M.D., Chairman

Brown Hotel, Louisville **December 15, 1960**

The KSMA Senior Day Committee, at its December 15 meeting, decided to hold the 1961 Senior Day program for the University of Louisville senior medical students on March 20 at the Kentucky Hotel.

This annual affair, which is sponsored by the KSMA in cooperation with the Jefferson County Medical Society and the University of Louisville School of Medicine, will have as its principal speaker, Mr. Chester Lauck of Houston, Texas, who is the former "Lum" of the "Lum and Abner" radio program.

It was agreed that the format used in previous years would be followed again this year.

Specialty Group Presidents

Frank Gaines, M.D., Chairman
Annual Meeting Scientific Program Committee

Brown Hotel, Louisville **January 5, 1961**

Called together to make plans for participation of the 13 specialty groups in the 1961 Annual Meeting of KSMA, the committee discussed the program to be presented, assignment of facilities and other procedures.

Doctor Gaines announced he was highly pleased with the progress made by the committee and predicted an outstanding program next September 19-21.

New Member of KSMA

Robert M. Sigler, M.D., Albany, is a new member of the Kentucky State Medical Association.



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KSMA Medical Education Office Features Four PG Courses

The KSMA Postgraduate Medical Education Office, in its regular listing of medical opportunities for the area, calls special attention to four postgraduate courses now being conducted or soon to be offered in Kentucky.

First to open was a 10-week course on Electrocardiography, which began January 11 at Louisville General Hospital and will continue each Wednesday, from 7 to 9 p.m., through March 15.

March 8-9 is the date set for a two-day program on Hematology at the new University of Kentucky Medical Center in Lexington. (The program was carried in the January issue of The Journal.)

Starting the middle or last of February, one-week training in the field of Obstetrics and Gynecology will be offered at Louisville General Hospital during 1961. Enrollment is limited to two physicians a week.

The fourth program is an intermittent course on Pediatrics to be held at Children's Hospital in Louisville on Tuesdays from April 4 through May 23. (The programs of the last two courses will be found on Page 166 of this issue of The Journal.)

The complete listing for Kentucky and nearby states through May follows:

February

Tuesdays to Mar. 15	Postgraduate course, "Electrocardiography"; Louisville General Hospital, Wednesday nights, 7 to 9; fee $35; KAGP Category One Credit applied for.
Weekly through 1961	Starting the middle or last of February, one-week training in the field of OB-GYN, each week during 1961 except April 17-29; May 15-20; October 2-7, and October 23-28; limit of two physicians per week; fee of $50 includes room at General Hospital, if desired. Enrollment should be made at least two weeks before desired participation. KAGP Category One Credit applied for.

March

6-10	Postgraduate course, "Pediatrics"; University of Tennessee, Memphis.
7-10	Visiting Professorship, Dr. Victor McKusick of Johns Hopkins University; at University of Kentucky; sponsored by Merck, Sharp & Dohme.
8-9	Postgraduate course, "Hematology"; University of Kentucky Medical Center, Lexington. Submitted for KAGP Category One Credit.
9-10	Postgraduate course, "Infertility and Endocrinology"; University of Michigan Medical Center, Ann Arbor.
13-14	Postgraduate course, "Neurology, Clinical"; University of Michigan Medical Center.
15-17	Postgraduate course, "Anesthesiology"; University of Tennessee, Memphis.
16-17	Postgraduate course, "Gastroenterology"; University of Nebraska, College of Medicine, Omaha.
20	Senior Day Program—Sponsored by the KSMA, Jefferson County Medical Society, and the University of Louisville; afternoon and evening, Kentucky Hotel.
20-24	Postgraduate course, "Electrocardiography"; University of Tennessee, Memphis.
22-23	Symposium on Heart Disease, sponsored by the Heart Association, and the University of Louisville; Brown Hotel, Louisville.
23	Pediatric Society meeting; Louisville, Sheraton Hotel.
24	Postgraduate course, "Physical Medicine"; University of Nebraska College of Medicine, Omaha.
24-25	Kentucky Chapter, American College of Surgeons, Annual Meeting; Louisville, Brown Hotel.
30	Postgraduate course, "Obstetrics (Lincoln)"; University of Nebraska College of Medicine, Omaha.

April

3-5	Postgraduate course, "Radiology-Diagnostic"; University of Michigan Medical School Center, Ann Arbor.
4-May 23	Postgraduate course, "Pediatrics"; Children's Hospital, Louisville, Tuesday mornings, 9:30 to 12:30; fee, $30 for the course or $5 per day. KAGP Category One Credit applied for.
5-7	Postgraduate course, "Ob-Gyn"; University of Tennessee Medical School, Memphis.
6	County Society Officers Conference; Lexington, Phoenix Hotel.
7-12	Ohio State Medical Association Annual Meeting; Netherlands Hilton Hotel, Cincinnati.
7-12	Tennessee State Medical Association Meeting; Reed House, Chattanooga.
12-13	Postgraduate course, "Pediatrics" (Tentative), Owensboro.
13	Kentucky Academy of General Practice Seminar, Ashland.
13-15	Postgraduate course, "Allergy"; University of Michigan Medical Center, Ann Arbor.
14-15	Medical Legal Conference, sponsored by the AMA; Louisville.
17-18	Postgraduate course, "Pediatrics"; University of Nebraska, Omaha.
17-21	Postgraduate Course, "Endocrinology and Metabolism"; University of Michigan Medical Center, Ann Arbor.
20-23	Postgraduate course, "Otolaryngology"; University of Michigan Medical Center.
24-26	Postgraduate course, "Rheumatology"; University of Michigan Medical Center.
24-26	Postgraduate course, "Ophthalmology"; University of Michigan Medical Center.
24-28	Postgraduate course, "Recent Advances in Therapeutics"; University of Michigan Medical Center, Ann Arbor.

Postgraduate Opportunities

(Continued)

May

2	Postgraduate course, "Anesthesiology"; University of Nebraska, Omaha.
3	Sixth Annual Trauma Day; University of Nebraska, Omaha.
4-5	Postgraduate course, "Urinary Tract Disease—Diagnosis and Treatment"; University of Tennessee, Memphis.
8-12	42nd Annual Session of the American College of Physicians; Miami Beach, Fla.
17-18	Postgraduate course, "Neurology"; University of Tennessee, Memphis.
24-26	Postgraduate course, "Diagnosis and Treatment—Emotional Disturbances in Children"; University of Tennessee, Memphis.
24-25	Postgraduate course, "Medicine" (Tentative); Harrodsburg, Ky.

Medical Foundation Elects

Paul G. Blazer, Jr., Ashland, has been elected president of the Kentucky Medical Foundation. He succeeds Francis M. Massie, M.D., Lexington.

The foundation is a nonprofit organization formed in Lexington in 1953 to enlist the aid of Kentuckians in obtaining a new medical school.

Danville Hospital Gets $44,000 For Mental-Health Study

Kentucky State Hospital, Danville, is one of nine psychiatric facilities selected by the National Institute of Mental Health to conduct a collaborative study of the effectiveness of different phenothiazine drugs on acute schizophrenic patients. A $44,000 grant has been awarded the Kentucky Mental Health Foundation, Inc., to carry out the project.

The one-year program will be directed by R. R. Knowles, superintendent of the hospital, assisted by Edgar A. Moles, hospital psychologist and psychology consultant for the Kentucky Department of Mental Health. Data collected on the 40 patients to be studied at Danville will be sent to the Psychopharmacology Service Center of the NIMH for processing and evaluation.

In other news released by the Department of Mental Health, announcement was made of an increase of from $90 to $127.50 a month in the rate of charge for treatment in Kentucky's four state mental hospitals. In noting the change, Department Commissioner H. L. McPheeters, M.D., pointed out that in view of increased advances in Kentucky's mental health program, including improved diet, more adequate facilities, additional personnel and increased freedom for patients, "it is necessary for the Department to increase its charge to maintain a high quality of service and to continue the pace of advancement."

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County Society Reports

Harrison County

The Harrison County Medical Society started the year 1961 with the following new officers: President, C. L. Thornberry, M.D.; vice-president, Kenneth W. Brumback, M.D.; secretary-treasurer, H. T. Smiser, M.D. All are Cynthiana physicians.

H. H. Moody, M.D., and Doctor Thornberry were named delegate and alternate, respectively, to the KSMA Annual Meeting in September, 1961.

Jefferson County

Everett H. Baker, M.D., was chosen president-elect of the Jefferson County Medical Society at the society's annual meeting held at the Medical Arts Building, Louisville, on January 16. He will take office in January, 1962.

Daniel G. Costigan, M.D., moved up to the presidency, succeeding George W. Pedigo, M.D.

Other newly-elected officers are: Homer B. Martin, M.D., first vice-president; Clyde T. Moore, M.D., second vice-president; L. Douglas Atherton, M.D., secretary; William P. Peak, M.D., treasurer; Roy H. Moore, Jr., M.D., and John J. Casey, M.D., judicial-council members.

McCracken County

The McCracken County Medical Society, at its year-end meeting, elected the following officers: Harry Abell, Jr., M.D., president; Joe B. Spaulding, M.D., vice-president, and William Smith, M.D., secretary. Expenditure of $100 by the new secretary for assistance in performing his duties was approved.

Also elected, for three-year terms, were: R. W. Robertson, M.D., and Leon Higdon, M.D., Executive Committee; Charles Harting, M.D., Board of Censors; Eugene Sloan, M.D., delegate to the KSMA; Martin S. Kleckner, Jr., M.D., alternate delegate, and Walter R. Johnson, M.D., chairman of the Committee on Legislation and Public Relations.

The six names to be submitted to the State for selection of three appointees to the local Board of Health were announced as follows: Walter R. Johnson, M.D.; Robert Wooldridge, M.D.; Chester M. Blanton, M.D.; O. D. Maxey, M.D.; Louis D. Myre, M.D., and Winfield Stryker, M.D.

A letter regarding the County Legislative Key Man System was read, and a motion was passed that the chairman of the Committee on Legislation and Public Relations (Doctor Johnson) be appointed the Key Man from McCracken County.

In other business, the society heard Doctor Johnson report on the AMA Clinical Meeting in Washington. Doctor Johnson was authorized to formulate a letter to be sent to the Kentucky Congressmen and Senators stating the position of the society on forthcoming legislation in Congress. A copy of this letter will be sent to the KSMA Headquarters Office.

Madison County

Max E. Blue, M.D., Richmond, is the new president of the Madison County Medical Society, succeeding John Armstrong, M.D., Berea. Other newly-elected officers are E. C. Whitaker, M.D., Berea, vice-president, and Eugene Bowling, M.D., Richmond, secretary.

Mason County

Claude Cummins, M.D., has been elected president of the Mason County Medical Society, succeeding W. M. Savage, M.D. Named secretary-treasurer, the office formerly held by Doctor Cummings, was Robert Blake, M.D.

Nelson County

The Nelson County Medical Society has elected Harry Spalding, M.D., as president for 1961. He succeeds A. D. Steely, M.D. Other officers named are K. L. Stinnette, M.D., vice-president, and Emmett Wood, M.D., secretary-treasurer.

Adair Hospital Dedicated

Dedication of the new $400,000 Adair Memorial Hospital at Columbia on December 18 was an important milestone for Adair Countians, since their nearest hospital had been at Campbellsville, 20 miles away. The modern brick building, offering the latest in hospital facilities, has 30 beds with room for expansion to 39 beds, according to J. H. Worstell, administrator.

Completion of the hospital culminated 10 years of community effort. Half of the money for the project was raised through a bond issue, and the other half came from a federal grant.

$460,000 Calhoun Hospital Opens

The new McLean County General Hospital at Calhoun was dedicated January 8, giving one of Kentucky's smallest counties $460,000 facilities for care of the sick. Calhoun has a population of 750, the county less than 11,000. The new modernistic, L-shaped hospital has 28 beds and complete surgical, X-ray and laboratory equipment. The administrator is Dean Wade who was associated with the Owensboro-Daviess County Hospital for 14 years.

PG Course In Israel Offered

A medical tour of Israel, constituting a clinical postgraduate program, will be offered by the University of California Extension's Department of Continuing Education In Medicine, April 20-May 15. The sessions have been planned in cooperation with a committee from the Hebrew University Hadassah School of Medicine in Jerusalem and the Beilinson and Tel-Hashomer Hospitals in Tel-Aviv. Opportunities will be provided for physicians to observe the rapid development of modern medical care in Israel. Inquiries concerning the tour may be addressed to: Dean of Continuing Education in Medicine, UCLA Medical Center, Los Angeles 24, Calif.

Dr. Griffing Named President of Sixth Trustee District

Waller H. Griffing, M. D., Bowling Green, was elected president of the Sixth Trustee District at the final meeting of 1960. He served the past two years as secretary.

Other officers named for 1961 were: Vice-president, John Burris, M.D., Morgantown, and secretary-treasurer, Lee Vensel, M.D., Franklin.

The scientific program was presented by James O. Willoughby, M.D., who talked on "Eye Injuries," and W. O. Carson, M.D., who discussed "Traumatic Shoulder Lesions." Both are Bowling Green physicians.

At the business session, it was decided to ask the cooperation of the secretary-treasurers of the individual medical societies of the district in collecting the previously-voted $1 dues.

The Warren-Butler-Edmonson Medical Societies were hosts at the meeting which was held at the Olde Fort Restaurant, Bowling Green.

142 Attend KAGP Seminar

Eighty-six physicians from Kentucky and 46 from Ohio registered for the Northern Kentucky Seminar of the Kentucky Academy of General Practice in Cincinnati on January 19. Total attendance, including the eight speakers on the program, was 142.

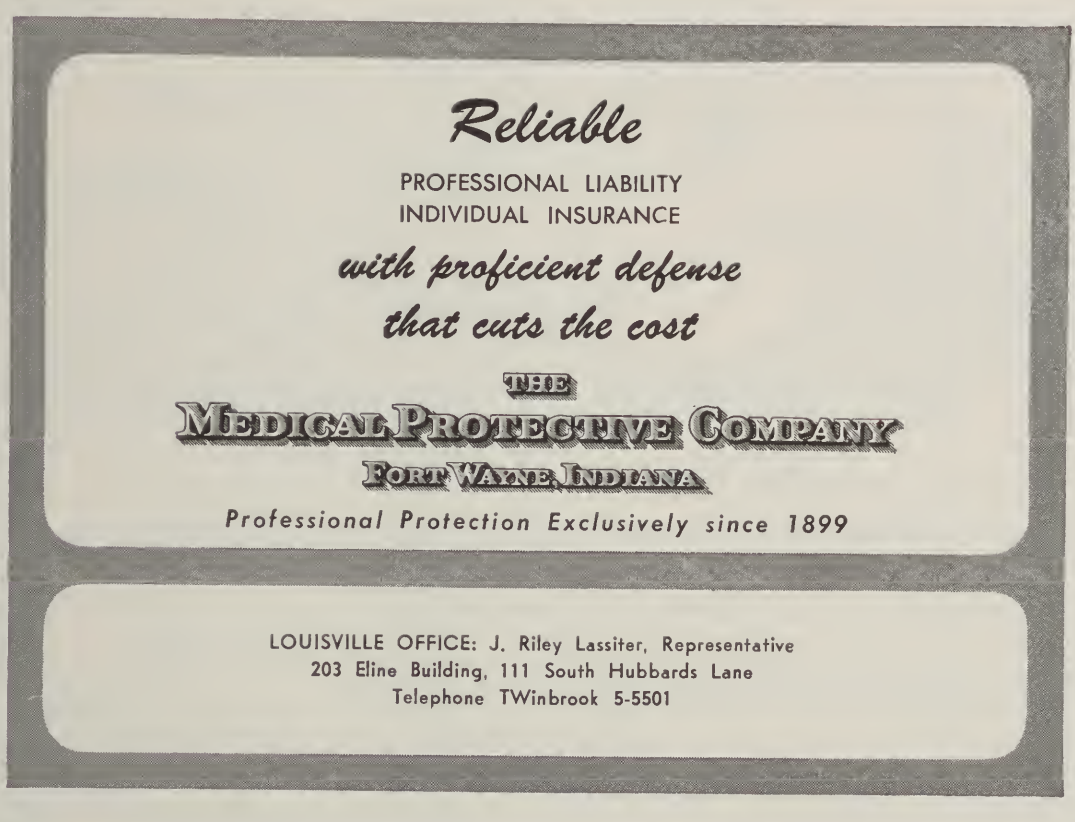
Health Department Reports Year Of Expansion and Growth

Growth and expansion marked the 1959-60 fiscal year of the Kentucky State Department of Health, according to the annual report of Commissioner of Health Russell E. Teague, M.D., to Governor Combs.

The year saw the construction of five new county health centers, three new hospitals and two additions, and one nursing home; the advent of the Division of Health Mobilization; the enlargement of services in the fields of venereal disease control and public health laboratories, and an increase in maternal and child health services. The expanded chronic disease control program made progress, and strides were made in combatting tuberculosis. The state's 74,153 live births outnumbered the 29,569 deaths by more than two to one.

During the year, the Department spent $6,082,251.09, the report said. Of this, $3,773,952.25 was allotted to 120 county health departments. Other major expenditures included: Administrative services, $475,944.11; engineering, $280,412.02; laboratories, $230,231.85; vital statistics, $128,501.57; preventive medicine, $114,724.57; local health services, $113,868.54; maternal and child health, $100,975.09.

Paul H. Wilson, M.D., has left Franklin to take a post at the Lakeside Medical Center, Detroit. Doctor Wilson moved to Franklin in April, 1960, from Miners' Hospital, McDowell.



In Memoriam

LESLIE H. LAYMAN, M.D.
Louisville
1906 - 1960

Leslie H. Layman, M.D., since 1946 a member of the medical staff of Veterans Hospital, Louisville, died unexpectedly on December 24 at the home of a brother in Elizabethtown. He was 54.

Doctor Layman was a lieutenant colonel in the Medical Corps during World War II, serving in France and Germany. He was a graduate of the University of Louisville School of Medicine.

EDGAR T. DENNIS, M.D.
Louisville
1889 - 1961

Edgar Thomas Dennis, M.D., practicing physician in Louisville for more than 40 years, died on January 4 at Waverly Hills Sanatorium.

A 1917 graduate of the Meharry Medical College, Doctor Dennis practiced in Western Kentucky before locating in Louisville. He was a member of the National Association for the Advancement of Colored People.

E. H. WEST, M.D.
Williamsburg
1882 - 1960

Edward Herbert West, M.D., a practicing physician in Whitley County for some 50 years, died Sunday night, December 11, at his home in Williamsburg. He was 78.

Doctor West was a 1907 graduate of the Hospital College of Medicine.

Two Groups Hear Dr. Lamont-Havers

R. W. Lamont-Havers, M.D.. New York, director of the Arthritis and Rheumatism Foundation, delivered two addresses in Louisville on January 12. Speaking to the foundation's Louisville chapter, he said that many useless treatments and drugs offered victims of arthritis and rheumatism are not only worthless, but often harmful.

Doctor Lamont-Havers made his second talk before the Louisville Society of Internal Medicine on the early diagnosis of arthritis and rheumatism.

Atlanta will be host on February 19 to the Southern Regional Conference on Perinatal Mortality and Morbidity, sponsored by the Committee on Maternal and Child Care of the AMA's Council on Medical Service. The program will be presented at the Biltmore Hotel, beginning at 9:30 a.m.

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For the diagnosis and treatment of
mental and nervous disorders, and
addictions to alcohol and drugs

Psychotherapy and occupational therapy

Electrical shock and insulin therapy as indicated

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In each capsule: Phenacetin (3 gr.) 194.0 mg.; acetylsalicylic acid (2½ gr.) 162.0 mg.; hyoscyamine sulfate 0.031 mg.; and phenobarbital (¼ gr.) 16.2 mg.

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PHENAPHEN with Codeine ..... ¼ gr.

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PHENAPHEN with Codeine ..... 1 gr.

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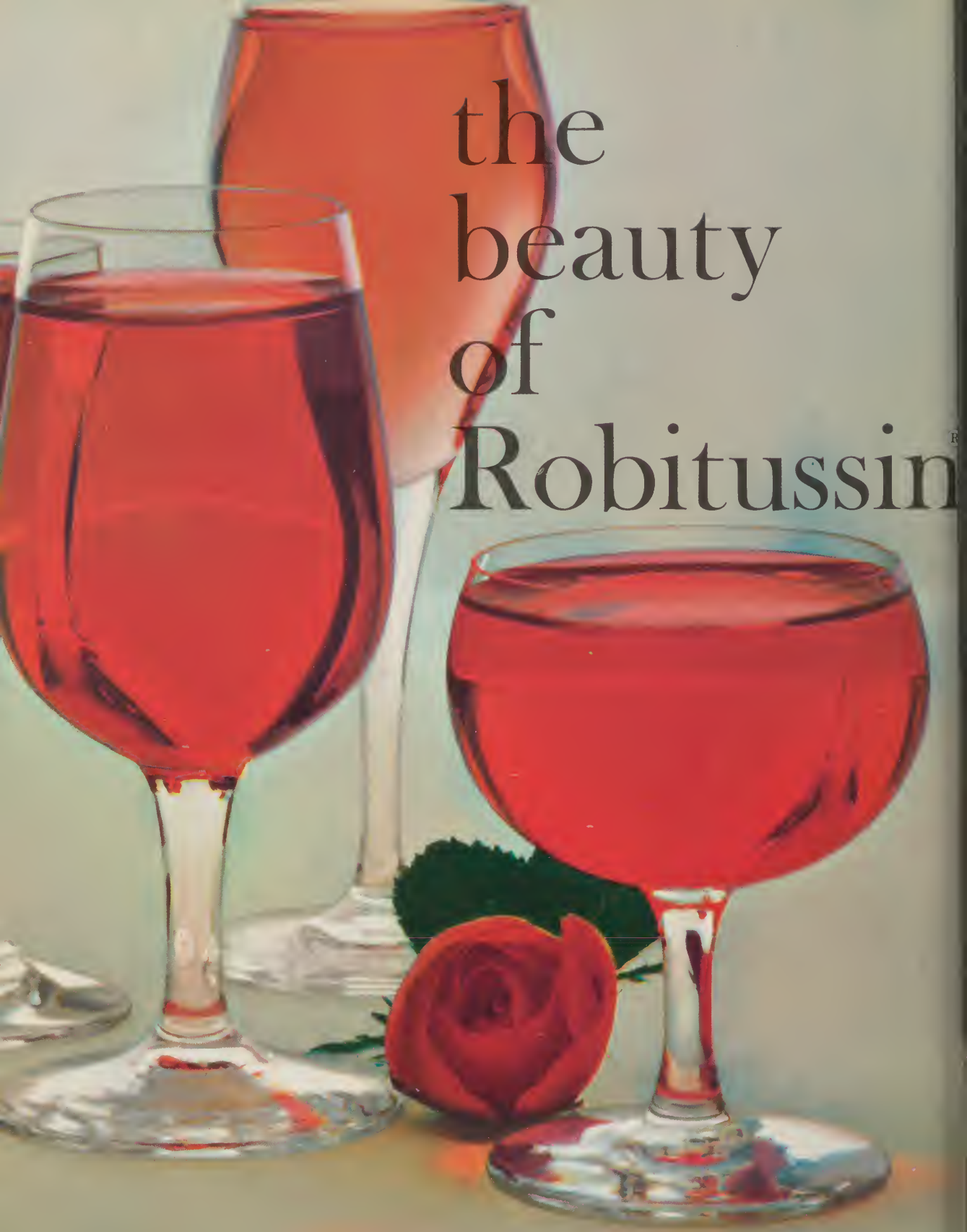
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What's she doing that's of medical interest?

She's drinking a glass of pure Florida orange juice. And that's important to her physician for several reasons.

How your patients obtain their vitamins or any of the other nutrients found in citrus fruits is of great medical interest—considering the fact there are so many wrong ways of doing it, so many substitutes and imitations for the real thing.

Actually, there's no better way for this young lady to obtain her vitamin C than by doing just what she is doing, for there's no better source than oranges and grapefruit ripened in the Florida sunshine. There's no substitute for the result of nature's own mysterious chemistry, flourishing in the warmth of this luxurious peninsula.

An obvious truth, you might say, but not so obvious to the parents of many teen-agers.

We know that a tall glass of orange juice is just about the best thing they can reach for when they raid the refrigerator. We also know that if you encourage this refreshing and healthful habit among your young patients — and for that matter, your patients of any age — you'll be helping them to the finest between-meals drink there is.

Nothing has ever matched the quality of Florida citrus—watched over as it is by a State Commission that enforces the world's highest standards for quality in fresh, frozen, canned or cartoned citrus fruits and juices.

That's why the young lady's activities are of medical interest.

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IN THE BOOKS



ADVENTURE TO MOTHERHOOD: by J. Allen Offen, M.D.; published by Audio Visual Education Company of America, Inc., Miami, Fla.; 34 pages; price, $2.95.

This is a hard-bound prenatal booklet that uses a somewhat different approach. Intended for both the patient and her husband, it portrays pictorially just what is done during the initial visit to the physician's office and the subsequent prenatal visits. Mention is made of prenatal classes in some localities.

The pictures from the Maternity Center Association in New York on "Having a Baby" are reproduced and portray the progressive intra uterine changes. The course in actual labor and delivery are depicted with good kodachromes which I feel tell their story well.

Included for physicians only, to be distributed as indicated, is a set of supplements; a personal health inventory for pregnancy plus several concise paragraphs on the following subjects: post partum instructions, constipation, hemorrhoids, the RH factor, cesarean section and diabetes in pregnancy.

In general, the author has avoided any controversial topics and the excellent photography should increase interest and educate the patient at the same time. The minimal amount of written material should mean more patient acceptance, especially among the less intellectual group, and actually help stimulate greater patient interest for good maternity care.

John A. Petry, M.D.

CLINICAL OBSTETRICS AND GYNECOLOGY, VOL. 3, No. 2: edited by Charles S. Stevenson, M.D., and Ernest W. Page, M.D.; published quarterly by Paul B. Hoeber, Inc.; 536 pages; price, $18 per year.

This book is divided into two parts and represents a symposium of two very important subjects of Obstetrics and Gynecology. Each section is divided into multiple articles written by authorities in their respective fields. This first half of the book is a symposium on the physiology of pregnancy. This section of the book varies widely in its coverage, ranging from physiology of the human placenta at term, feto-maternal gas exchange, hormones in pregnancy, and a final article on the physiology of uterine contraction.

Each article is accompanied by rather extensive references, grafts and charts. The articles are short, concise, and to the point, and each article has a very valuable summary at its conclusion.

Reading through the symposium on the physiology of pregnancy is one that is rather time consuming as most of the work is laboratory in nature. It can be of great value in understanding some of the problems which occur in the so-called normal pregnancy. There is no definite correlation made between the laboratory data that is available and clinical syndromes which might occur. Each article, however, is carefully selected, well prepared, and should be of great value in understanding the physiological nature of the normal pregnancy.

The second section of the book is a symposium on endometriosis. It is a very thorough coverage of this very common condition, with seven articles ranging from pathology of the disease, symptoms, sterility and fertility in women with endometriosis, the surgical and medical treatment of endometriosis, and the concluding article on some general and special consideration of endometriosis along with some very interesting case presentations. This very complete coverage of the subject of endometriosis is very valuable and covers all aspects that one might run into whether doing General Medicine, General Surgery, or Obstetrics and Gynecology.

The second section of this book differs considerably from the first section in that it is practically all clinical and should be thoroughly read by any person who comes in contact with this very common disease of endometriosis.

The entire volume is well prepared and should be an excellent reference and source of information for any doctor concerned with the problems of pregnancy and endometriosis.

O. J. Hayes, M.D.

EDEMA, Mechanisms and Management—A Hahnemann Symposium on Salt and Water Retention: edited by John H. Moyer, M.D., and Morton Fuchs, M.D.; published by W. B. Saunders Company, Philadelphia and London; 833 pages; price, $15.

This book is a compilation of papers on the mechanisms and management of edema of all causes. There is a total of 123 authors and contributors to this symposium. The papers are grouped into eight different sections. The first section is on fluid in electrolyte balance. This is followed by pharmacology and therapeutic use of diuretics, then sections on iatrogenic edema, hypertension, toxemia of pregnancy and premenstrual tension, edema of renal origin, edema associated with liver disease and, finally, congestive heart failure.

There is of necessity some degree of overlap in the various sections but this does not distract from the value of the book. The papers in general are concise and to the point, clearly written and with excellent bibliography.

I heartily recommend this book as one to be included in the library of any one practicing internal medicine. It is much too comprehensive to be classified as a text but can be used as a valuable and comprehensive reference for the latest thoughts in this complicated field.

F. Albert Olash, M.D., F.A.C.P.



in premenstrual tension only neo Bromth® treats the whole syndrome





It was the introduction of neo Bromth several years ago that created such widespread interest in the premenstrual syndrome—because of neo Bromth's specific ability to prevent the development of the condition in the first place.

The action of neo Bromth is not limited merely to control of abnormal water retention, or of nervousness, or of pain—or any other single or several of the multiple manifestations characteristic of premenstrual tension. neo Bromth effectively controls the *whole* syndrome.

neo Bromth is also completely free from the undesirable side effects associated with such limited-action therapy as ammonium chloride, hormones, tranquilizers and potent diuretics. neo Bromth has continued to prove to be the safest—as well as the most effective—treatment for premenstrual tension.

Each 80 mg. tablet contains 50 mg. Pamabrom, and 30 mg. pyrilamine maleate. Dosage is 2 tablets twice daily (morning and night) beginning 5 to 7 days before menstruation. Discontinue when the flow starts.

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From the files of the
COMMITTEE FOR THE
STUDY OF MATERNAL MORTALITY



CASE # 74, 1959: A 22 year old white married gravida 3 para 1 ab 1 first consulted her physician in the second month of pregnancy, and subsequently made twelve prenatal visits. Her last menstrual period had begun on November 18, 1958, so the expected date of delivery was August 25, 1959. Her second pregnancy had terminated in July, 1957, with the passage of a hydatidiform mole. No subsequent follow-up studies were reported. There were no abnormal physical findings. At regular prenatal visits, recorded findings were:

Month of Pregnancy	2	3	4	5	6	7	8	9		
Blood Pressure	100/50	110/50	115/60	115/60	105/60	110/70	100/50	110/60	112/60	100/40
Weight	118¾	155	124½	132	136½	142	142½	143½	142½	145
Urine	Neg.	Neg.	Neg.	Neg.	Neg.	Neg.	Neg.	Neg.	Neg.	Neg.
Rh	Pos.									
Serology	Neg.									

Spontaneous labor began at term. During the first stage, which lasted 9 hours, the patient received 1 cc mepergan for analgesia. The membranes ruptured spontaneously. The second stage lasted 1½ hours and culminated in the delivery by outlet forceps extraction of a living infant weighing 8 pounds, 6 ounces. The only additional information supplied was that the third stage lasted 30 minutes and that the postpartum course was normal for at least one hour following the delivery. No mention was made of the type of anesthesia, if any was administered. Shortly after delivery, the blood pressure and pulse were normal and the fundus was firm.

Two hours following delivery, the patient was found to be bleeding severely. The hastily-summoned physician found her in shock, and examination showed the uterus greatly enlarged and boggy. It failed to contract despite intravenous oxytocics and manual stimulation.

Although the cervix was reinspected for lacerations, none were found. A consultant recommended that a hysterectomy be performed if the bleeding could not be controlled. Four pints of whole blood, 2 units of dextran, and liberal use of vasopressors and fibrinogen failed to control the bleeding or reverse the shock sufficiently to attempt the hysterectomy. No mention was made of the clotting characteristics of the blood. The patient died four hours after delivery. No autopsy was performed.

This protocol demonstrates once again the recurring problem of inadequate clinical information for adequate evaluation by the Committee. Since attending physicians rarely accept the Committee's invitation to attend its discussions of their cases, much detailed information is essential for intelligent discussion; such information is rarely available.

The record states that the patient under discussion had a normal blood pressure and pulse and the uterus was firm one hour following delivery. The next notation was not made until two hours following delivery, when the physician was summoned because the patient was hemorrhaging.

Since the preventable factors all occurred immediately postpartum, the Committee classified this case as a direct obstetrical death. Confronted with such a sudden hemorrhage not originating in an unsuspected laceration of the cervix, the possibility of initially hidden rupture of the uterus must be considered. Nothing mentioned in the abstract suggested a possible uterine rupture at delivery; however, there is a remote possibility that the antecedent hydatidiform mole might have invaded the myometrium enough to produce a localized weakness which might predispose to uterine rupture.

Postpartum hemorrhage continues to be an important cause of maternal death, since it is often a sudden, unpredictable emergency. Even in large urban hospitals, procurement of blood for emergency transfusion may entail delay which can prove fatal; this would seem to be at least one area in which improvement could be achieved.

IN CONTRACEPTION...



PHOTOGRAPH: HUMAN SPERMATOZOA 400X. HEMOCYTOMETER DIFFUSION TEST.

WHY IS DIFFUSION IMPORTANT?

Because the active ingredients of a spermicidal preparation must diffuse rapidly into the seminal clot and throughout the vaginal canal to be clinically effective. Lanesta Gel offers this *dual* protection. Its four spermicidal agents quickly invade the clot to stop the main body of sperm. It spreads evenly and quickly throughout the vaginal canal—seeks out every wrinkle and fold that may offer concealment to sperm. With this rapid diffusion, your patient receives full benefit of the swift spermicidal action of Lanesta Gel — in minutes — a decisive measure in conception control.

In Lanesta Gel *7-chloro-4-indanol,* a new, effective, nonirritating, nonallergenic spermicide, produces immediate immobilization of spermatozoa in dilution of up to 1:4,000. The addition of 10 per cent NaCl in ionic form greatly accelerates spermicidal action. Ricinoleic acid facilitates rapid inactivation and immobilization of spermatozoa and sodium lauryl sulfate acts as a dispersing agent and spermicidal detergent.

Lanesta Gel with a diaphragm provides one of the most effective means of conception control. However, whether used with or without a diaphragm, the patient and you, doctor, can be certain that Lanesta Gel provides faster spermicidal action — plus essential diffusion and retention of the spermicidal agents in a position where they can act upon the spermatozoa.



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Supplied: Lanesta Exquiset® . . . with diaphragm of prescribed size and type; universal introducer; Lanesta Gel, 3 oz. tube, with easy clean applicator, in an attractive purse. Lanesta Gel, 3 oz. tube with applicator; 3 oz. refill tube — available at all pharmacies.

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PUBLIC HEALTH PAGE

Accidents—A Major Public Health Problem

RUSSELL E. TEAGUE, M.D., M.P.H. *Commissioner of Health Commonwealth of Kentucky*

ACCIDENTS continue to plague Kentucky citizens. Each year approximately 2,000 Kentuckians die from accidental causes, and more than 30,000 are seriously injured. Kentucky's five-year average accidental death rate is 66.7 per 100,000 as compared to 56.0 for the United States.

When we analyze the causes of death, we find accidents are fourth for all ages and first for the 1-44 age group. In magnitude of number and relative importance, this is very significant, but what is even more important are the potential years of livelihood lost from this needless cause. Heart and cancer diseases also lead accidents, but these strike hardest in the later or twilight years of life.

Is it necessary that nearly one-half of the deaths among the school-age children of Kentucky stem from accidents? Can nothing be done to stop this flow of human waste? Is it that nothing can be done to reduce the huge number of non-fatal, but permanent injury accidents?

It is perhaps typical of man that we have sought comfort in the conventional programs and practices, and in the things which are countable and common; but when we look around us, there is on every side evidence that the incidence of accidental injury can be reduced with startling significance. Our friends in industry, the safety engineers, have made remarkable progress in this direction. The traffic engineers have been able to make progress even in the face of ever increasing numbers of more lethal machines.

If we cannot afford the luxury of a captive audience or the expediency of predetermined controls with which to work, we can still be functional in accident prevention. Indeed it is said that upward of 70 per cent of accidents are the results of human factors. These human factors are principally attitudes and resultant behavior in the presence of accident-provoking situations.

Who is in better position to influence human behavior than the practicing physician in his face-to-face relationship with his patients? What person in the community is in better position than the physician to stimulate and lead his fellow citizens to a state of accident awareness?

The busy physician is not, and should not, be alone in this endeavor. There are many other disciplines already in the field. There is a great need for community leadership to unite and coordinate these forces to combat this major health problem.

Historically, it has been members of our ranks who have led the fights against other wanton destroyers of human life in other days. Are accidents so different that we should now turn our backs on what is the greatest public health problem today?

Since accidents are regarded as a leading and proper concern of public health, the State Department of Health maintains a Division of Accident Prevention. It is not conceived that personnel of this division can contribute much to the solution of the problem on a firsthand basis. It is, however, felt necessary that somewhere there should be a coordinating and re-

(Continued on Page 190)

when you suspect
it may become more
than just a cold...



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Only a single prescription provides:

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- **symptomatic relief** of aches, pains, fever, coryza and rhinorrhea associated with upper respiratory infections
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Each
TETREX-APC with BRISTAMIN
Capsule contains:

ANTIBIOTIC
TETREX (tetracycline phosphate complex equivalent to tetracycline HCl) ..... 125 mg.

ANALGESIC — ANTIPYRETIC
Aspirin ..... 150 mg.
Phenacetin ..... 120 mg.
Caffeine ..... 30 mg.

ANTIHISTAMINIC
BRISTAMIN (phenyltoloxamine citrate) ..... 25 mg.

Dosage: Adults: 2 capsules 3 or 4 times a day for 3 to 5 days.
Children: 6 to 12 yrs.: One-half the adult dose.

Supplied: Bottles of 24 and 100 capsules.

According to a report by the Council on Drugs of the American Medical Association,* antibiotics may be administered for prophylaxis against secondary bacterial invaders in the following types of patients with influenza: pregnant women; debilitated infants; older individuals; patients being treated for other bacterial infections with chemotherapeutic agents, and patients with chronic, nonallergic respiratory disease.

*Council on Drugs, J.A.M.A. 165:58 (Sept. 7) 1957.

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for relief of anxiety and tension

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1. simple dosage schedule produces rapid, reliable tranquilization without unpredictable excitation
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Miltown®

meprobamate (Wallace)

Usual dosage: One or two 400 mg. tablets t.i.d.
Supplied: 400 mg. scored tablets, 200 mg. sugar-coated tablets.
Also as MEPROTABS* — 400 mg. *unmarked,* coated tablets; and as MEPROSPAN® — 400 mg. and 200 mg. *continuous release* capsules.

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of clinical use...



...for the tense and nervous patient

Despite the introduction in recent years of "new and different" tranquilizers, Miltown continues, quietly and steadfastly, to gain in acceptance. Meprobamate (Miltown) is prescribed by the medical profession more than any other tranquilizer in the world.

The reasons are not hard to find. Miltown is a ***known*** drug. Its few side effects have been fully reported. ***There are no surprises in store for either the patient or the physician.***

NEW analgesic

Kills pain



stops tension

For neuralgias, dysmenorrhea, upper respiratory distress, postsurgical conditions... new compound kills pain, stops tension, reduces fever—gives more complete relief than other analgesics.

Soma Compound is an entirely new, totally different analgesic combination that contains three drugs. First, Soma: a new type of analgesic that has proved to be highly effective in relieving both pain and tension.* Second, phenacetin: a "standard" analgesic and antipyretic. Third, caffeine: a safe, mild stimulant for elevation of mood. As a result, the patient gets more complete relief than he does with other analgesics.

Soma Compound is nonnarcotic and nonaddicting. It reduces pain perception without impairing the natural defense reflexes.*

NEW NONNARCOTIC ANALGESIC

soma® Compound

Composition: Soma (carisoprodol), 200 mg.; phenacetin, 160 mg.; caffeine, 32 mg.
Dosage: 1 or 2 tablets q.i.d.
Supplied: Bottles of 50 apricot-colored, scored tablets.

NEW FOR MORE SEVERE PAIN

soma® Compound + codeine

BOOSTS THE EFFECTIVENESS OF CODEINE: Soma Compound boosts the effectiveness of codeine. Therefore, only ¼ grain of codeine phosphate is supplied to relieve the more severe pain that usually requires ½ grain.

Composition: Same as Soma Compound plus ¼ grain codeine phosphate.
Dosage: 1 or 2 tablets q.i.d.
Supplied: Bottles of 50 white, lozenge-shaped tablets; subject to Federal Narcotics Regulations.

References available on request.

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PUBLIC HEALTH PAGE

(Continued from Page 184)

source unit to assist the great number of individuals who must work for its abatement.

Through contract arrangements, and by drawing on other divisions of the Department, the Division of Accident Prevention provides medical, para medical, psychiatric and engineering consultation to those who find need of such services in safety programs. Wide selections of films and literature are also available. In addition, continuous study is made toward finding new and more effective answers to problems particularly in the area of farm, home and school safety.

In conclusion, it should be stated again that accidents are felt to be an ameliorable problem encompassing individual, community and public health agencies, but one which particularly needs the kind of local leadership and initiative that can be provided by the practicing physician.

WASHINGTON NEWS

(Continued from Page 118)

aged under Social Security an Administration priority bill for early submission to Congress.

But some key Democrats in Congress announced they would not go along with President Kennedy on the issue. Sen. Robert S. Kerr (D., Okla.), co-author of the medical-care-for-the-aged program approved by Congress last year, said it should be financed by a general tax—"not a limited tax like Social Security."

Similar opposition to the Social Security approach was expressed by Sen. John J. Sparkman (D., Ala.). Chairman Harry F. Byrd (D., Va.) of the Senate Finance Committee earlier had said he was convinced that providing medical care for the aged under Social Security would lead to socialized medicine and possibly bankrupt the Social Security trust fund.

Despite the Kennedy Administration's espousal of the Social Security plan, the AMA pledged its continued cooperation to the Department of Health, Education and Welfare on other health programs.

A group of AMA officials headed by Doctor Askey told the news HEW secretary, former Gov. Abraham Ribicoff of Connecticut, at a pre-inaugural conference that the Association "pledges its continued cooperation to HEW to work for the best medical care for the nation." The AMA "has always had a deep sense of responsibility for the health needs of the people," Doctor Askey said.

The AMA officials also advised Ribicoff that they would help implement the Kerr-Mills law in any way possible.

PLAN TO ATTEND

March 22 and 23, 1961

7th Annual Symposium on Cardiovascular Diseases

THE BROWN HOTEL—LOUISVILLE, KENTUCKY

Wednesday, March 22, 1961

"Development and Use of the Prothrombin Test"

ARMAND J. QUICK, Ph.D., M.D., Professor of Biochemistry and Director of the Department, Marquette University School of Medicine, Milwaukee, Wisconsin.

"Postphlebitic Syndrome"

JOHN M. HOWARD, M.D., Professor of Surgery, Hahnemann Hospital, Philadelphia, Pennsylvania.

"Fibrinolysin"

ANTHONY P. FLETCHER, M.D., Assistant Professor of Medicine, Washington University School of Medicine, St. Louis, Missouri.

Panel on "Thromboembolic Disease"

J. HERMAN MAHAFFEY, M.D., Moderator; ARMAND J. QUICK, Ph.D., M.D., JOHN M. HOWARD, M.D., ANTHONY P. FLETCHER, M.D.

"Vascular Headaches"

CHARLES D. ARING, M.D., Professor of Neurology, University of Cincinnati College of Medicine, Cincinnati, Ohio.

"Newer Specialized Diagnostic Techniques"

EUGENE BRAUNWALD, M.D., Chief, Section of Cardiology, Clinic of Surgery, National Heart Institute, Bethesda, Maryland.

"Surgery of Coronary Artery Disease"

ARTHUR M. VINEBERG, Ph.D., M.D., Assistant Professor of Surgery, McGill University, Montreal, Quebec, Canada.

"Renal Artery Disease as a Cause of Hypertension"

EUGENE F. POUTASSE, M.D., Staff Urologist, Cleveland Clinic Foundation, Cleveland, Ohio.

"My Life and Hard Times as a Cardiologist"

IRVINE H. PAGE, M.D., Director of Research, Cleveland Clinic Foundation, Cleveland, Ohio and Past President of The American Heart Association.

Thursday, March 23, 1961

"The Treatment of Arterial Hypertension"

IRVINE H. PAGE, M.D., Director of Research, Cleveland Clinic Foundation, Cleveland, Ohio.

"The Present Status of the Management of Atherosclerosis"

LOUIS N. KATZ, M.D., Director of Cardiovascular Department, Michael Reese Hospital, Chicago, Illinois.

"Nutrition and Arteriosclerosis"

GRACE A. GOLDSMITH, M.D., Professor of Medicine, Tulane University School of Medicine, New Orleans, Louisiana.

Panel on "Management of Atherosclerosis"

WALTER S. COE, M.D., Moderator; IRVINE H. PAGE, M.D., LOUIS N. KATZ, M.D., GRACE A. GOLDSMITH, M.D.

"Cardiac Manifestations in Malignant Carcinoid"

SYLVESTER E. GOULD, M.D., Professor of Pathology, Wayne University School of Medicine, Detroit, Michigan.

"Abnormal Electrocardiograms in Normal Subjects"

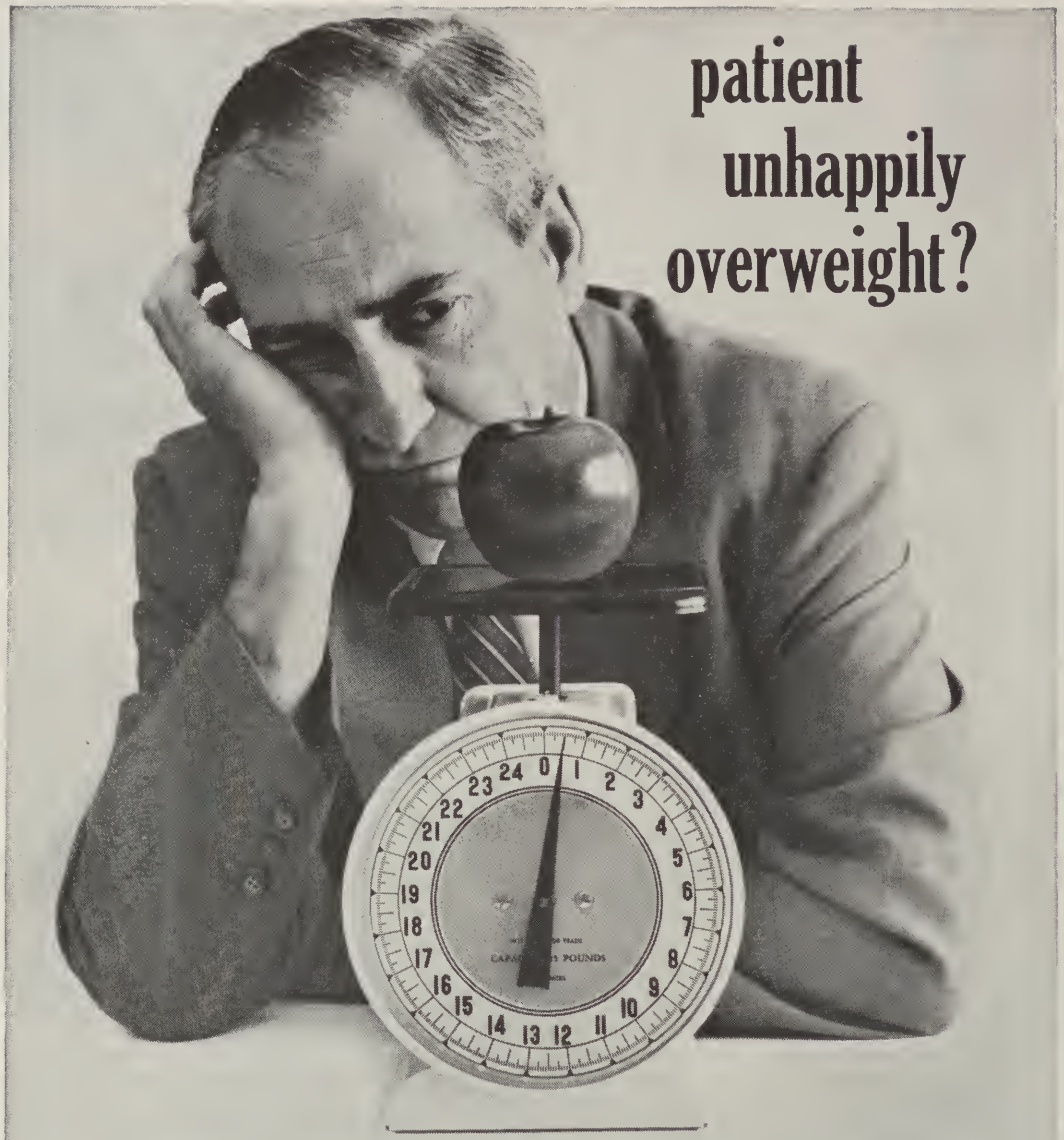
HENRY J. L. MARRIOTT, M.D., Associate Professor of Medicine, University of Maryland School of Medicine, Baltimore, Maryland.

Clinical Pathological Conference

DRS. GOULD, GOLDSMITH, MARRIOTT AND KATZ.

Registration Free

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Controls food craving, keeps the reducer happy—In obesity, "our drug of choice has been methedrine . . . because it produces the same central effect with about one-half the dose required with plain amphetamine, because the effect is more prolonged, and because undesirable peripheral effects are significantly minimized or entirely absent."[1] Literature available on request.

Supplied: Tablets 5 mg., scored. Bottles of 100 and 1000.

[1] Douglas, H. S.: West. J. Surg. 59:238 (May) 1951.

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in infectious disease[17,22,30,36]
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in malabsorption syndrome[1,2,6,27]
in degenerative disease[6,7,19,20,40]
in cardiac disease[23,28,29,38,41]
in dermatitis[24,39]
in peptic ulcer[8,21,38]
in neuroses & psychiatric disorders[25,26]
in diabetes mellitus[31,32,33,38]
in alcoholism[9,11,35,37,38]
in ulcerative colitis[10,14,16]
in osteoporosis[13,19,20]
in pancreatitis[15]
in female climacteric[12,34]

Patients with chronic disease deserve the nutritional support provided by

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Squibb Vitamin-Minerals for Therapy

11 vitamins, 8 minerals
clinically-formulated and potency protected to provide
enough nutritional support
to do some good

with vitamins only
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also available:
Theragran Liquid
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Theragran products do not contain folic acid.

1-41 a list of the above references will be supplied on request.

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When it's more like "grippe" or



"flu" than a simple cold, but an antibiotic is not indicated... prescribe NEW WIN-CODIN* Tablets

New Win-Codin tablets provide greater symptomatic relief from influenza, colds and sinusitis than do simple analgesic-antihistamine combinations. New Win-Codin tablets contain a full complement of the most effective agents available to relieve general discomfort, bring down fever and lessen congestive symptoms.

Each tablet contains:

Codeine phosphate 15 mg.—to relieve local and generalized pain and control dry cough

Neo-Synephrine® 10 mg.—to shrink nasal membranes and open sinus ostia

Acetylsalicyclic acid 300 mg. (5 grains)—to reduce fever and relieve aching

Chlorpheniramine maleate 2 mg.—an antihistamine to shrink engorged membranes and lessen rhinorrhea

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New Win-Codin tablets will bring more comfort to many patients suffering from severe colds, influenza or sinusitis.

Average dose: Adults, 1 or 2 tablets three times daily; children 6 to 12 years, from ½ to 1 tablet three times daily.

Available in bottles of 100 (Class B narcotic).

Winthrop LABORATORIES
New York 18, N. Y.

*Trademark †For persons with vitamin C deficiency
Neo-Synephrine (brand of phenylephrine), trademark reg. U. S. Pat. Off.

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ANNOUNCING A CHANGE IN NAME
without change in formula or patient benefits

Centalex is now called

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Trademark

a cerebral tonic-stimulant fortified with neurotropic vitamins



helps the geriatric patient return from the shadow-land of senility

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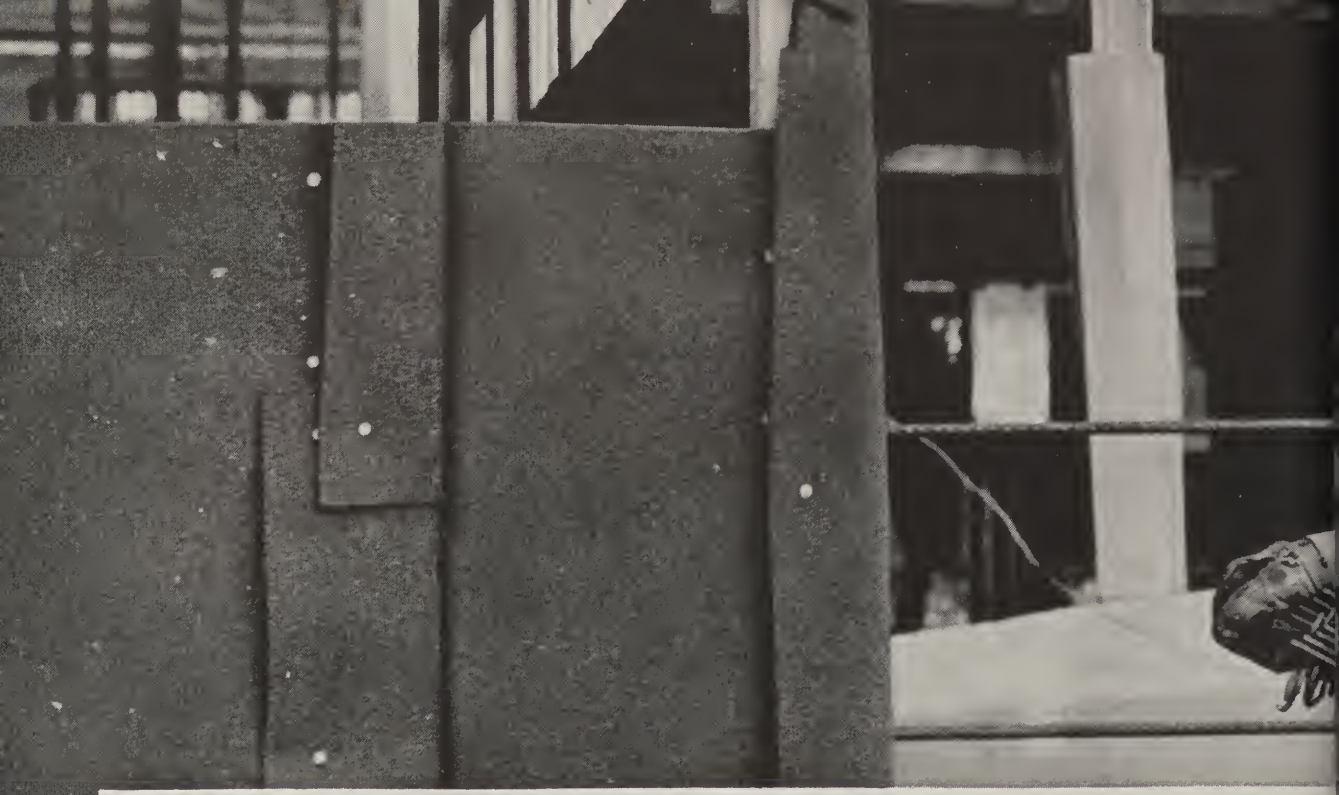
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Each teaspoonful (5 ml.) contains 100 mg. Cenalene (brand of pentylenetetrazol), 1.67 mg. thiamine HCl, 7.5 mg. niacinamide, and 2.5 mcg. cyanocobalamin (vitamin B_{12}); alcohol, 15%. **Available** in bottles of one pint and one gallon.

Literature on request

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Wallace Laboratories, Cranbury, New Jersey



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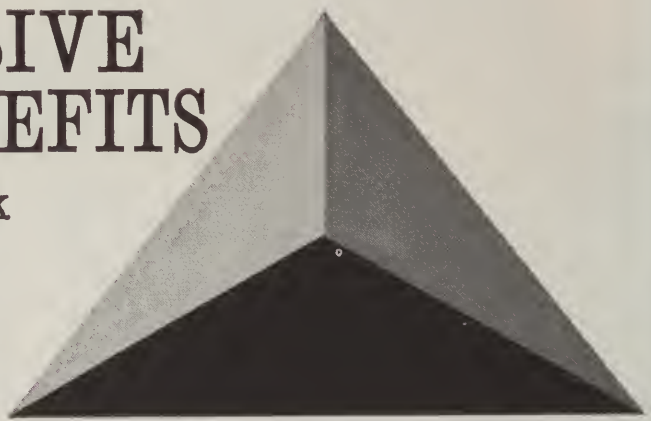
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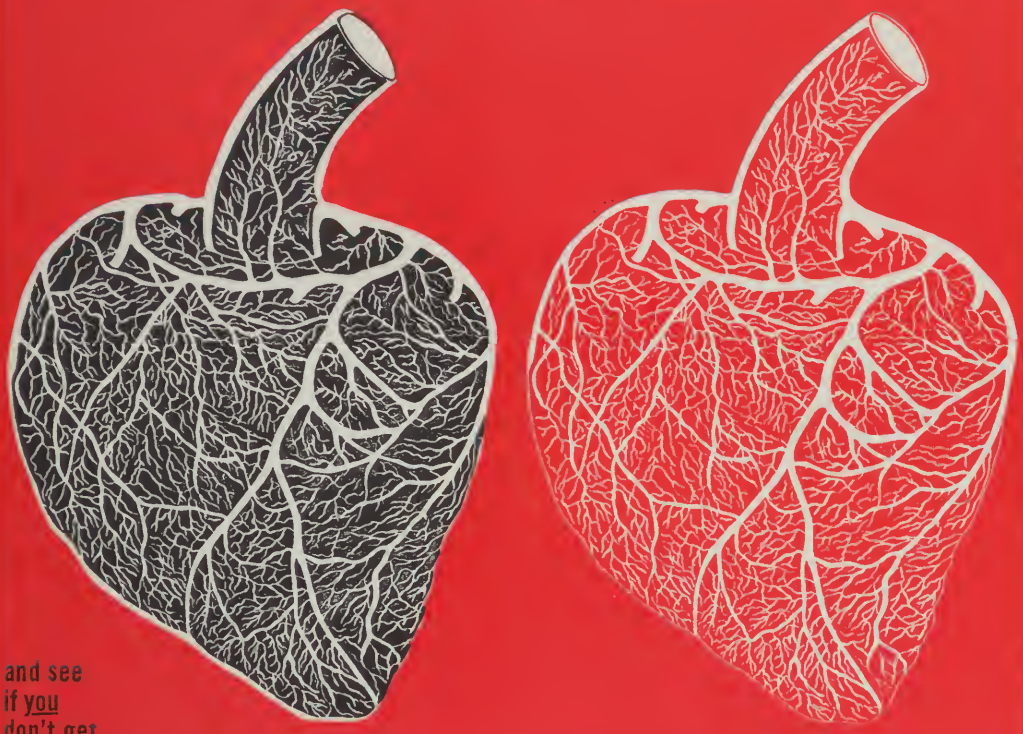
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*Clark, T. E., in press.

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†pentaerythritol tetranitrate ††brand of hydroxyzine

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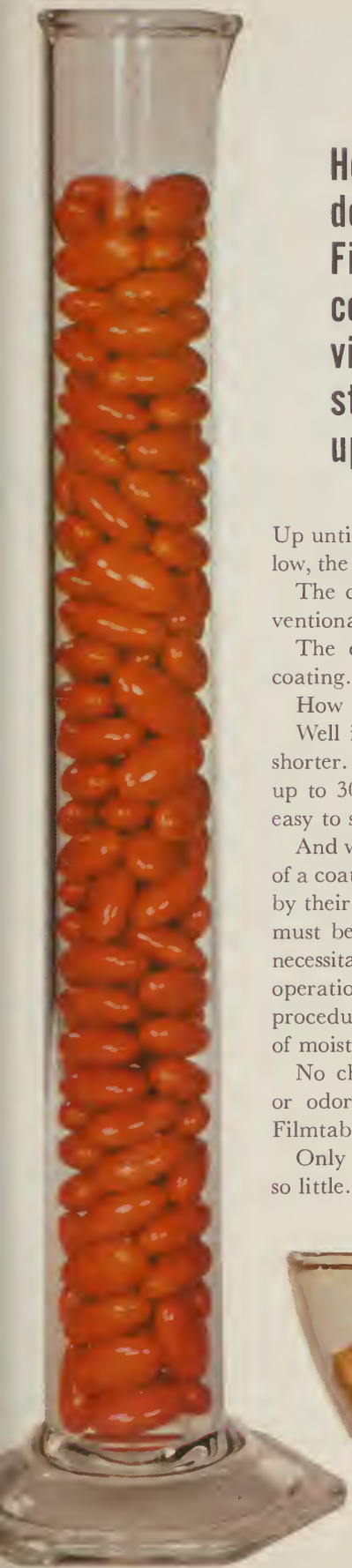
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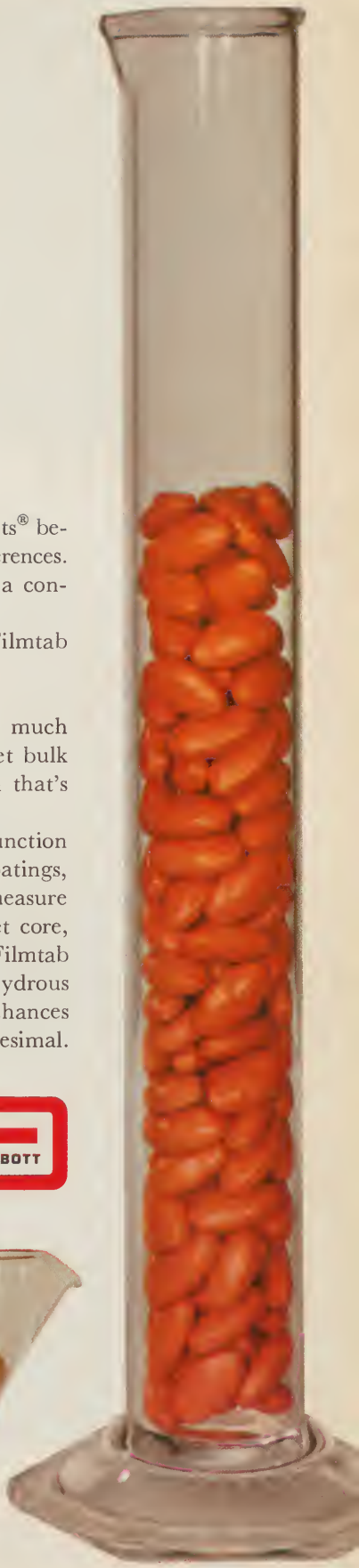
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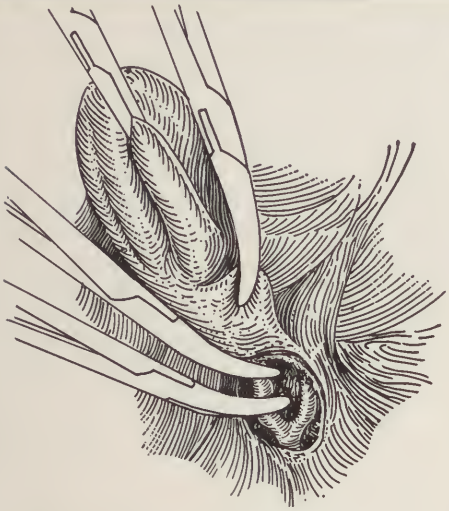
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Source: Farris, J. M., and Smith, G. K.: M. Clin. North America *43*:1133 (July) 1959.

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President's Page*



Dr. Coleman
Vice-President — Central

A Challenge

AT present, and for the foreseeable future, we of the medical profession are, and will be, challenged from all sides to justify our position in the composite picture of our American way of life. To be sure, we must admit that in most of our recent encounters with "the opposition" in the press, and on radio and television, we have not always presented our image in its well deserved and true perspective.

In view of the fact that the last national election has tremendously strengthened the hand of those who are working toward the total socialization of our American life, we must all pitch in and do our utmost in helping to stem the tide. This can not be done by each of us individually.

First, we must all become thoroughly familiar with the political and socio-economic problems of our 20th Century economy. Then, we should be willing and eager to present organized medicine's image whenever the opportunity arises. We must be in a position to welcome debate with representatives of labor, government officials, and social workers; most important is that we give our own patients clear-cut and adequate answers to the many questions that have arisen during the last several months in regard to American medical care.

If we are to have a part in shaping the destiny of American medicine, we must each individually become a member of medicine's socio-economic task force. As a member of that group, we should grasp every opportunity to present the true picture to civic groups, church groups, labor groups, or individuals. To do anything else at the present time indicates failure to discharge our full obligations as American physicians.

Foster Coleman, M.D.
Vice-President—Central

* *This is the second of a series of four guest articles written at the invitation of Richard G. Elliott, M.D., KSMA president.*



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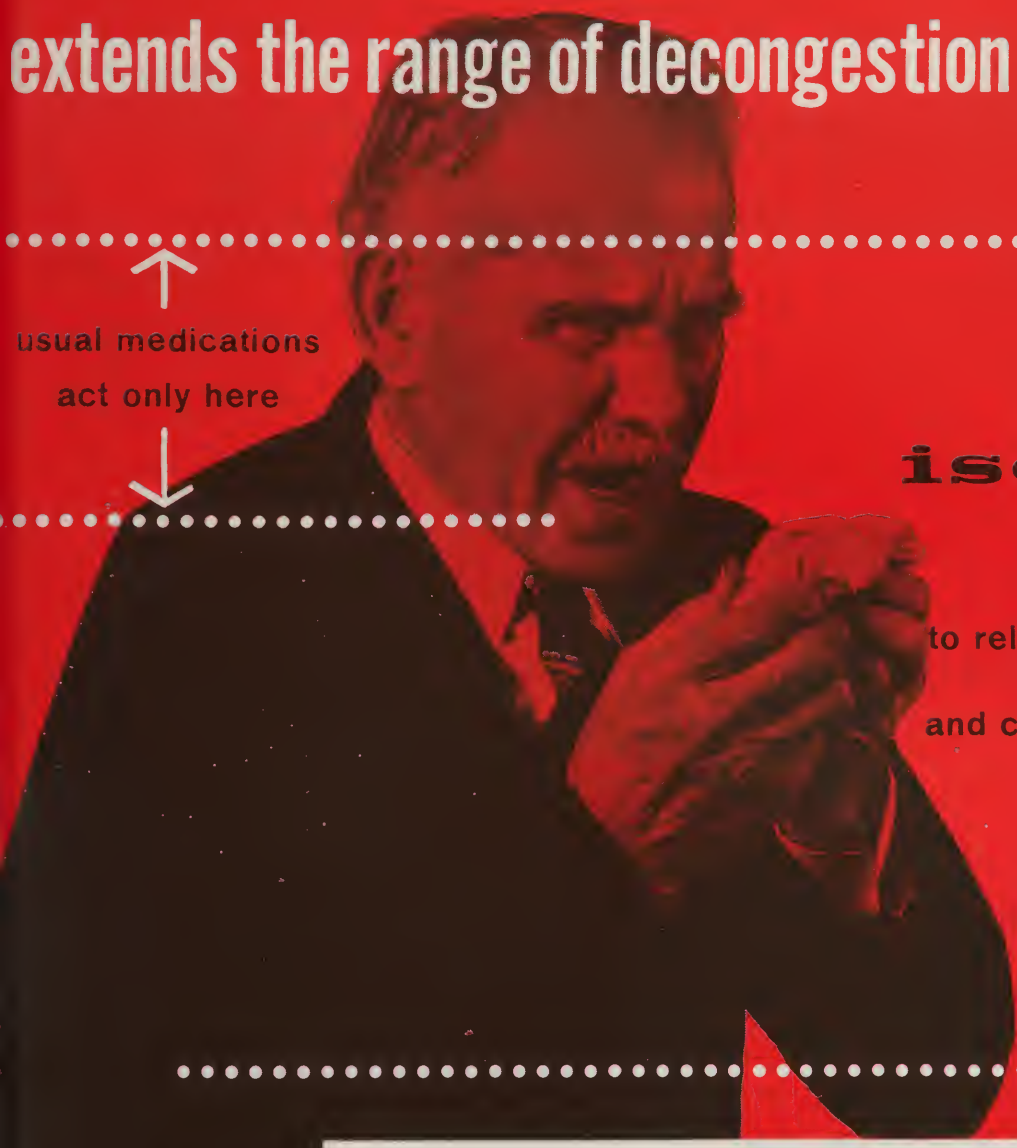
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1. Aviado, D. M. et al: J. Pharmacol. & Exper. Therap. 122: 406-417 (Mar.) 1958. 2. Laboratory Report: Research Div., Chas. C. Haskell & Co., 1959.

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THE INSURANCE PAGE



Lack Of Understanding*

MOST of the complaints and criticism encountered by health insurance, hospitalization insurance and prepayment medical plans have been traced to a lack of understanding of the types of insurance and the limitations of various plans. It would seem that the solution is to supply the needed explanations and information to the public. Doctors can do much in this field by explaining to their patients when asked about insurance.

It has to be repeated many times that hospitalization insurance and medical care insurance were designed at a low premium rate to take care of only the serious cases definitely needing hospital care; and fees or indemnities for medical care were originally paid only for surgical cases, fractures, injuries and maternity care. The reason for this is that the incidence of such cases can be predicted well enough to make them insurable.

The Medical Rider has been made available to allow daily indemnity for serious medical disease requiring more than three days hospitalization. The Medical Rider is designed for serious medical cases only, and cannot under the present premium rate be used for comprehensive medical care. Abuse of insurance plans by hospitalization of mild and ambulatory illnesses ordinarily treated as out-patients or office patients would cause an increase in premium rates and so would destroy the effectiveness of the plans.

We believe that the public wants hospitalization insurance and medical care insurance priced low enough to be within their means. Abuse of hospitalization insurance must not be tolerated, because abuse would cause a drastic increase in premium rates and make the insurance plans impractical. Of course, the important thing is that willful abuse is fraud.

It is up to the doctors to have understanding and to promote better understanding for their patients. Doctors should repeat the simple fact that the prepayment plans are to help meet the cost of large medical bills, such as major operations and serious medical disease; and the patient is expected to be able to pay the smaller medical fees of office or out-patient treatments, or any ambulatory non-surgical illness.

John Dickinson, M.D.

**Guest editor is John Dickinson, M.D., Glasgow, president of the Board of Directors of Kentucky Physicians Mutual.*



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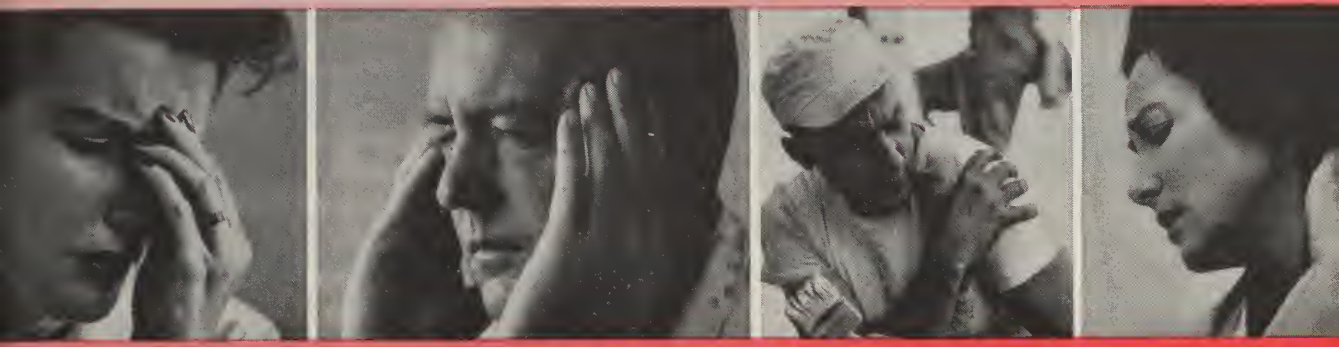
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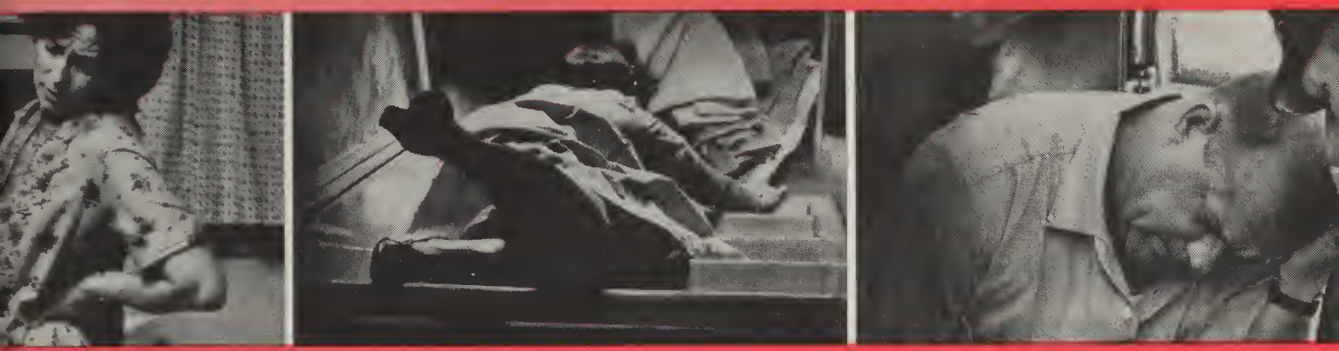
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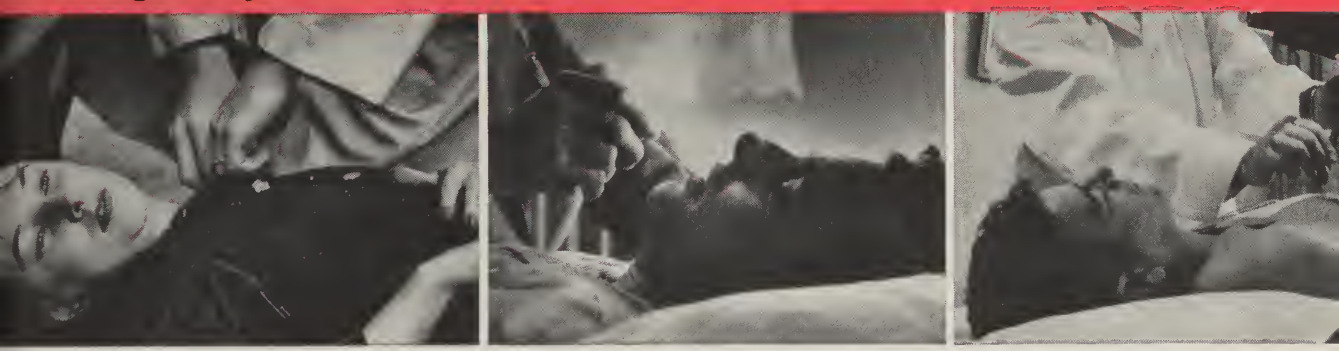
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*U.S. Patent Nos. 2,628,185 and 2,907,768

WASHINGTON NEWS DIGEST

Washington, D. C.—President Kennedy asked Congress to increase social security taxes to finance limited medical care for elderly persons on the social security rolls, a plan opposed by the medical profession.

The proposal was part of a sweeping health program outlined by Kennedy in a special message to Congress during his first month in the White House.

The Kennedy program also included federal aid for construction and operation of medical schools, scholarships for medical and dental students, grants for community nursing and hospital services, stepped-up medical research and expanded federal activity in the field of child and youth health.

Under Kennedy's proposal, social security beneficiaries 65 years and older could get up to 90 days of hospitalization for each single illness. However, the patient would have to pay $10 daily for the first nine days of hospitalization with a minimum payment of $20.

After release from a hospital, the elderly person could get up to 180 days in a nursing home. The social security program also would provide for payment by the government of all out-patient diagnostic costs in excess of $20 and community visiting nurse services.

•

The program would be financed by increased social security taxes by one-fourth of one per cent on both employers and workers and by three-eighths of one per cent on self-employed persons covered by social security. The social security tax base also would be increased from the present $4,800 a year to $5,000.

Enactment of this proposal, coupled with another Kennedy recommendation and increases in the social security tax already scheduled in the law, would mean that workers and employers would be paying $250 each in social security taxes in 1969.

Nationwide television audiences were told by an American Medical Association spokesman why the medical profession supports the Kerr-Mills program of medical care for the aged and opposes tieing it in with social security.

In television debates with Sen. Hubert Humphrey (D., Minn.) on NBC-TV and Walter Reuther, organized labor spokesman, on CBS-TV, Edward R. Annis, M.D., of Miami, Fla., described the Kerr-Mills program as "sound and effective." He said it "must be given the chance it deserves."

"Congress passed it because it believed that the important thing was to help the people who need help; to help them quickly; and to help them through the machinery of local government," Doctor Annis said.

•

The AMA Board of Trustees charged the CBS network with "misrepresentations, bias, and distortions" on another program: "The Business of Health—Medicine, Money and Politics."

The network edited out of the taped program the AMA's true position on health care for the aged:

"The AMA believes that any medical care plan is both unsound and unfair which would compel working people to shoulder increased social security taxes to finance health costs of all those over 65 (under social security), rich and poor alike, regardless of whether they want or need such help and which, at the same time, ignores millions of indigent elderly who do need help."

Kennedy's health program faced strong opposition in Congress. The concensus of Capital Hill observers was that it stood a 50-50 chance of getting Congressional approval but not before it had been cut down. There were some who doubted that the Administration's program for medical care of the aged would be acted upon, at least by both houses of Congress before next year.

•

Even some Democratic Congressmen with the liberal label were taken back by the scope of Kennedy's health program.

Arthur H. Motley, president of the Chamber of Commerce of the United States, warned that social security taxes are being increased to a point "where people might rebel against the whole Social Security system."

He contended that this nation's present personal medical care system is the best of any large nation.

"It's worth crusading for and that is what the Chamber is doing," Motley said.



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1. Barden, F. W., et al.: J. Maine M. A. 46:99, 1955.
2. Ford, R. A., and Blanchard, K.: Journal-Lancet 78:185, 1958.

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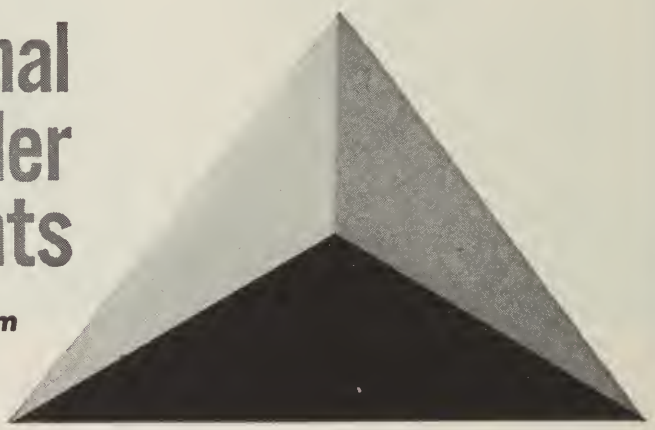
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Intravenous route: 1 Gm. every 6 hours using 50 ml. of sterile saline solution at the rate of 10 ml. per minute.

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DIRECTIONS FOR RECONSTITUTION

Add 1.5 ml. sterile distilled water or normal saline to a 1 Gm. vial and shake vigorously. Withdraw the clear, reconstituted solution (2.0 ml.) into a syringe and inject. The reconstituted solution contains 500 mg. of STAPHCILLIN per ml. Reconstituted solutions are stable for 24 hours under refrigeration.

For intravenous use, dilute the reconstituted dose in 50 ml. of sterile saline and inject at the rate of 10 ml. per minute.

*This statement supersedes that in the Official Package Circulars dated September and/or October, 1960.

(continued)

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(continued)

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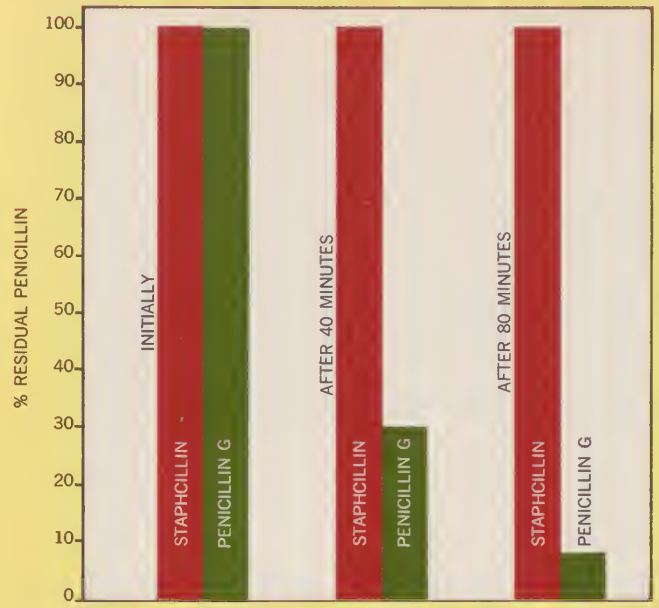
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1. Youmans, J. B.: Am. J. Med. 25:659 (Nov.) 1958

cardiac diseases "Who can say, for example, whether the patient chronically ill with myocardial failure may not have a poorer myocardium because of a moderate deficiency in the vitamin B-complex? Something is known of the relationship of vitamin C to the intercellular ground substance and repair of tissues. One may speculate upon the effects of a deficiency of this vitamin, short of scurvy, upon the tissues in chronic disease."[2] 2. Kampmeier, R. H.: Am. J. Med. 25:662 (Nov.) 1958.

arthritis "It is our practice to prescribe a multiple vitamin preparation to patients with rheumatoid arthritis simply to insure nutritional adequacy . . ."[3]
3. Fernandez-Herlihy, L: Lahey Clinic Bull. 11:12 (July-Sept.) 1958.

digestive diseases Symptoms attributable to B-vitamin deficiency are commonly observed in patients on peptic ulcer diets.[4] Daily administration of therapeutic vitamins to patients with hepatitis and cirrhosis is recommended by the National Research Council.[5] 4. Sebrell, W. H.: Am. J. Med. 25:673 (Nov.) 1958. 5. Pollack, H., and Halpern, S. L.: Therapeutic Nutrition, National Academy of Sciences and National Research Council, Washington, D. C., 1952, p. 57.

degenerative diseases "Studies by Wexberg, Jolliffe and others have indicated that many of the symptoms attributed in the past to senility or to cerebral arteriosclerosis seem to respond with remarkable speed to the administration of vitamins, particularly niacin and ascorbic acid. These facts indicate that the vitamin reserve of aging persons is lowered, even to the danger point, more than is the case in the average American adult."[6] 6. Overholser, W., and Fong, T.C.C. in Stieglitz, E. J.: Geriatric Medicine, 3rd edition, J. B. Lippincott, Philadelphia, 1954, p. 264.

infectious diseases Infections cause a lowering of ascorbic acid levels in the plasma; and the absorption of this vitamin is reduced in diarrheal states.[7] 7. Goldsmith, G A.: Conference on Vitamin C. The New York Academy of Sciences, New York City, Oct. 7 and 8, 1960. Reported in: Medical Science 8:772 (Dec.10) 1960.

diabetes Diabetics, like all patients on restricted diets, require an extra source of vitamins.[8] "Rigidly limiting the bread intake of the diabetic patient automatically eliminates a large amount of thiamin from the diet. . . . There is some evidence of interference with normal riboflavin utilization during catabolic episodes."[9]
8. Duncan G. G.: Diseases of Metabolism 4th edition W. B. Saunders, Philadelphia, 1959, p. 812. 9. Pollack, H.: Am. J. Med. 25:708 (Nov.) 1958.

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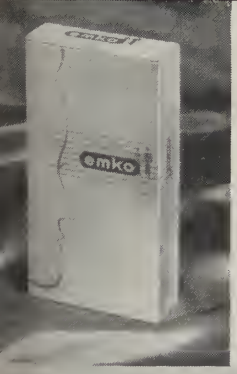
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VOL. 59 MARCH, 1961 NO. 3

Diagnosis of Rheumatoid Arthritis*

J. DOUGLAS RUFF, M.D.

Lexington, Ky.

Useful criteria for the diagnosis of rheumatoid arthritis are suggested by a committee of the American Rheumatism Association. Most important of these are based on clinical observations

IN general, the diagnosis of a specific disease is based on one or more characteristics which identify the disease. In some diseases, such as syphilis, diabetes mellitus and hyperparathyroidism, the diagnosis may depend upon a single report from the laboratory. The diagnosis of rheumatoid arthritis, however, usually is based on a composite of characteristic historical data and objective physical findings. Except for the purpose of excluding other diseases, roentgenograms and laboratory procedures are usually not necessary for diagnosis of this disease.

I will review the diagnostic criteria for rheumatoid arthritis proposed by a committee of the American Rheumatism Association[1] and present data obtained by applying these criteria to 100 records of patients with the diagnosis of rheumatoid arthritis. These patients were seen during the past three years by physicians in one medical section at the Lexington Clinic. Photographs taken of these patients illustrate certain physical findings.

Criteria for Diagnosis

The four groups suggested were: Classical Rheumatoid Arthritis; Definite Rheumatoid Arthritis; Probable Rheumatoid Arthritis; and Possible Rheumatoid Arthritis. A specific number of the eleven criteria in Table 1 are required for each group and the last group has slightly different criteria (Table 2). The first five criteria (Table 1) must be present continuously for six weeks and the physical findings must have been observed by a physician. The criteria are now considered individually.

TABLE 1
Criteria for "Classical," "Definite," "Probable" Rheumatoid Arthritis

1. Morning stiffness
2. Pain or motion or tenderness in 1 joint
3. Swelling (objective) in 1 joint
4. Swelling in 1 other joint (free interval not more than 3 months)
5. Symmetric joint swelling
6. Subcutaneous nodules (1 or more)
7. Typical x-ray changes
8. Positive test for "rheumatoid factor"
9. Poor mucin precipitate from synovial fluid
10. Histologic changes in synovial membrane
11. Histologic changes in nodules

"Classical" = 7 of above criteria; first 5 present 6 weeks
"Definite" = 5 of above criteria; first 5 present 6 weeks
"Probable" = 3 of above criteria; 1 of first 5 present 6 weeks

Morning stiffness (Criteria 1): This typical symptom of arthritis and rheumatism is a

* *Presented at Fourth Annual Fall Clinical Conference, Lexington Clinic, Lexington, Kentucky, October 21 and 22, 1959.*

temporary restriction of motion accompanied by muscular aching and tenderness and is relieved totally or partially by a few moments or hours of physical activity. It is also referred to as "secondary fibrositis."

TABLE 2
Criteria for
"Possible" Rheumatoid Arthritis

1. Morning stiffness
2. Tenderness or pain on motion
3. Joint swelling
4. Subcutaneous nodules
5. Elevated sedimentation rate or C-reactive protein
6. Iritis

"Possible" = 2 of above criteria.
Joint symptoms present 3 weeks.

Joint findings (Criteria 2 through 5): As the disease primarily affects joint synovia and is characterized by joint tenderness and, or swelling, *an adequate examination of all joints is of obvious importance.* This should include inspection, palpation, and an estimate of range of motion. The temporo-mandibular joints are frequently involved and frequently not examined (Figure 1a). Sternoclavicular joints are easily examined and also frequently involved (Figure 1b).

Hands are "the calling cards" of arthritis and typical fusiform symmetrical swelling of metacarpophalangeal joints and proximal interphalangeal joints almost justifies a "snap diagnosis" of rheumatoid arthritis (Figure 2a). Careful palpation will demonstrate that apparent swelling of osteoarthritis is caused by projection of bone spurs and Heberden's nodes (Figure 2b). The latter is almost never accompanied by joint swelling or synovial thickening. Osteoarthritis never involves metacarpophalangeal joints and rheumatoid arthritis seldom involves distal interphalangeal joints.

Arthritis of the knee joints is less characteristic in this disease and is more easily confused with other arthritides. Tender heels and persistently tender and swollen metatarsophalangeal joints should make one suspect rheumatoid arthritis. The presence of *metatarsalgia* or *sore heels* is indication for careful examination of these areas which are so frequently neglected. It is well to examine normal metatarsal joints for comparison. In gout, the medial aspect of the great toe is most tender while in rheumatoid arthritis tenderness is greater when pressure is



Figure 1a—Palpation of temporomandibular joint.
Figure 1b—Sternoclavicular joint.



Figure 2a—Rheumatoid arthritis. Palpation reveals that the fusiform swelling is due to synovial thickening.
Figure 2b—Typical osteoarthritis. Proximal and distal interphalangeal joints are made prominent by bone spurs, cysts and Heberden's nodes.



Figure 3a—Rheumatoid arthritis of long standing which has caused destruction of metatarsophalangeal joints with subluxation and lateral deviation.
Figure 3b—A typical subcutaneous nodule of rheumatoid arthritis is on extensor surface of forearm.

exerted above and below. Lateral deviation and subluxation of toes occurs with chronic involvement (Figure 3a).

Subcutaneous nodules (Criteria 6): Their presence is an important diagnostic sign and they usually overlie extensor tendons and are frequently found below the elbow joint (Figure

3b). The subcutaneous nodule of rheumatic fever is transient, whereas the nodule of rheumatoid arthritis usually persists for months or years. Olecranon bursitis may be present in both gout and rheumatoid arthritis (Figure 4a).



Figure 4a
Olecranon bursitis in rheumatoid arthritis.

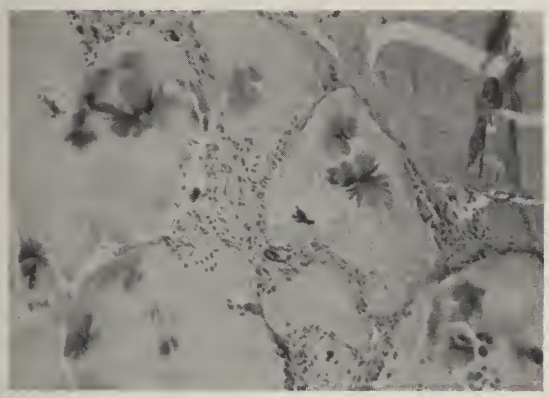


Figure 4b
Uric acid deposits in knee joint (necropsy specimen). Tissue was fixed in absolute alcohol to preserve uric acid crystals.

X-ray changes (Criteria 7): While there are clearly defined bone and joint characteristics, physical findings are usually adequate for differential diagnosis.

Rheumatoid factor (Criteria 8): There is a substance in the serum of persons with rheumatoid arthritis which has a capacity to agglutinate sensitized particulate bodies such as sheep erythrocytes and particles of latex and bentonite.[3] The latex test was used in some of these cases and the findings will be discussed later.

Poor Mucin Precipitate from Synovial Fluid (Criteria 9): Upon the addition of acetic acid, mucin precipitates as a ropy clot in normal and traumatic joint effusions. In septic and rheumatoid effusions the clot is poor and the solution turbid. Synovial fluid removed for examination in these cases was not tested for this characteristic except in several instances.

Histologic changes in Synovial Membrane (Criteria 10): Typically there is villous hypertrophy, proliferation of superficial synovial cells, infiltration by chronic inflammatory cells with a tendency to form lymphoid nodules, deposition of compact fibrin, and foci of cell necrosis. Although these changes are nonspecific and have been described in other diseases,[2] biopsy of the synovium is often helpful and probably should be done more frequently. It is occasionally helpful in the diagnosis of an atypical case of gout (Figure 4b). When there is persistent monoarticular arthritis, biopsy should always be done to exclude specific infection, synovial tumor, etc.

Histologic changes in rheumatoid nodules (Criteria 11): There is a central necrotic zone of eosinophilic staining material surrounded by a palisade of swollen fibroblasts.

Characteristics of 100 Cases

Diagnosis: The criteria for the four groups of rheumatoid arthritis were applied to 100 records with the diagnosis, "rheumatoid arthritis" (Table 1). In only 1 (1%) of the cases with the diagnosis "rheumatoid arthritis" were the requirements for the diagnosis "Classical Rheumatoid Arthritis" met. This was obviously due to the fact that additional diagnostic tests were not done. In 48 (48%) the requirements for the diagnosis, "Definite Rheumatoid Arthritis" were met. In most instances, these requirements were obtained by history and physical examination only.

Nineteen (19%) met the requirements for the diagnosis "Possible Rheumatoid Arthritis." Twenty-two (22%) did not meet the requirements necessary for inclusion in any of these groups. Some of these had features of diseases excluding the diagnosis, rheumatoid arthritis (Table 3). One had erythema nodosum, two had lymphomas, one had gout (the diagnosis was based on biopsy of synovium), and one had carcinoma of the kidney. Most of the remaining 15 patients had symptoms more suggestive of rheumatoid arthritis than of rheumatic fever or gout, but sufficient criteria

were not met for any of the four categories.

Sex: Of the 78 cases meeting requirements for one of the four categories, 44 were female and 34 male. This is a ratio of 1.2 to 1. The usual ratio found has been 3 to 1.

Age of onset: The average was 34.5 years. There were seven females and no males with onset in their second decade. There was a greater number of both sexes with onset in their fifth and sixth decades.

Weight: The average weight was 141 pounds. There was no apparent increased involvement of weight bearing joints.

Anemia: The average hemoglobin of the 78 cases meeting diagnostic criteria was 11.3 grams. The lowest hemoglobin was 9.0 grams. There is evidence that the etiology of the anemia accompanying rheumatoid arthritis is caused by bone marrow suppression in addition to an occasional decrease in red cell life span.

Sedimentation rate: The average sedimentation rate (Westergren) was 74 mm. per hour. It is my impression that this is valuable as an index of activity of the disease and is only occasionally an important diagnostic aid.

Other manifestations: Only four of these patients had iritis. Two had clinical evidence of valvular heart disease. Two had Felty's syndrome i.e. rheumatoid arthritis with splenomegaly and associated reduction of one or more of the peripheral blood elements. In one of these, recurrent infections occurred and there was persistent neutropenia. There was good response to splenectomy. Two had Sjögran's syndrome i.e. dry mouth and eyes resulting from deficient secretions from lacrimal and salivary glands.

Latex Test for Rheumatoid Factor: While this test was not used in a statistically significant number of these cases, it is my impression that the test is sufficiently specific but not sufficiently sensitive to be a great diagnostic aid. In all the cases with positive tests, other criteria were already adequate for diagnosis. In a recent report of 259 cases of "definite rheumatoid arthritis," 36% had negative Latex fixation tests. In the same report there was only 4% with positive tests in a group of patients with miscellaneous diseases.

Rheumatoid spondylitis involves the spine and sacroiliac joints, affects men about nine times as often as women and seldom affects peripheral joints. There were six instances of this disease during the same period in which the 100 cases of rheumatoid arthritis were seen. This disease is probably a variant of rheumatoid arthritis. These cases are not included in this review.

TABLE 3
Diseases or Features Excluding Rheumatoid Arthritis*

Clinical disseminated lupus erythematosus	Reiter's syndrome
Lupus erythematosus cells	Shoulder-hand syndrome
Periarteritis nodosa	Hypertrophic pulmonary osteoarthropathy
Dermatomyositis	Neuro-arthropathy
Scleroderma	Homogentisic acid in urine
Rheumatic fever	Sarcoid
Clinical gouty arthritis	Multiple myeloma
Tophi	Erythema nodosum
Infectious arthritis	Leukemia or lymphoma
Tubercle bacilli in joints	Agammaglobulinemia

*These exclusions were listed by the Committee of the American Rheumatism Association.

Summary

A committee of The American Rheumatism Association has listed precise and useful criteria for the diagnosis of rheumatoid arthritis. These criteria are reviewed and applied to 100 cases with the diagnosis "rheumatoid arthritis."

It is apparent from this analysis that the diagnosis in most instances is based on clinical findings and observations. In occasional cases additional diagnostic aids are helpful in confirming the clinical impression. Diagnostic x-ray, the sedimentation rate of the blood, tests for rheumatoid factor, and histologic findings of biopsied synovia and nodules are all helpful at times. There is still no specific test for the *diagnosis* which must be based on clinical grounds.

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Osteoarthritis And Symptomatic Arthritis*

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Osteoarthritis is the commonest form of arthritis. In differentiating it from rheumatoid arthritis, the erythrocyte sedimentation rate is the most useful test employed

Osteoarthritis

IT is a well established fact that the commonest form of arthritis encountered by those interested in the specialty of rheumatology is osteoarthritis. While rheumatoid arthritis is primarily a disease which has its onset in the early decades of life, osteoarthritis is primarily a disease afflicting after the fourth decade. A large percentage of people over 50 years of age have some manifestation of osteoarthritis. In many of them, the disease produces few or no symptoms, while in others the symptoms at times are pronounced and troublesome. Synonyms often used for "osteoarthritis" include "hypertrophic arthritis," "degenerative arthritis," and "senescent arthritis."

Osteoarthritis, in its typical form, has a predilection for certain joints, namely, the terminal phalangeal joints of the fingers, the shoulders, back, hips and knees. Although the process may involve more than one of these joints, it usually is most pronounced in one. In striking contrast, rheumatoid arthritis usually affects the middle, rather than the terminal, phalangeal joints of the fingers. In rheumatoid arthritis, involvment of the hands, wrists, elbows, ankles and joints of the feet is the rule, whereas these joints rarely, if ever are involved in osteoarthritis.

This report is concerned with an analysis of 100 cases of osteoarthritis which have come under my observation during the five-year period ending July 1, 1959. This group of cases represents only a portion of the total number seen by the entire staff of the Lexington Clinic.

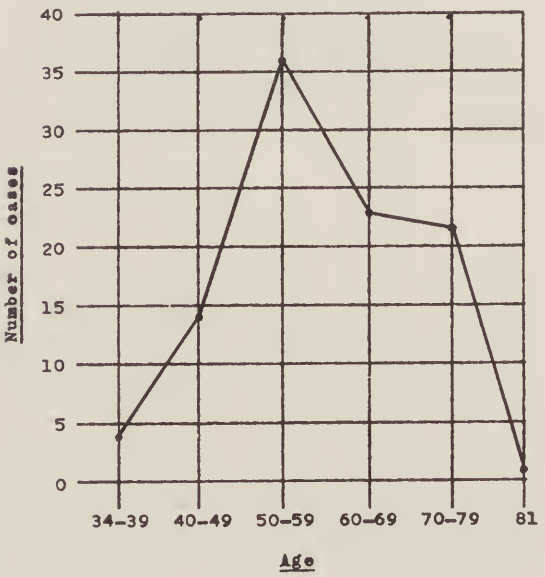


Figure 1

Age Distribution of Osteoarthritis (100 Cases)

Analysis of 100 Cases

Age. An analysis of the 100 cases reviewed reveals that only 14 (14 per cent) of these individuals in whom the diagnosis of osteoarthritis was made were between 40 and 49. Thirty-six (36 per cent) of the patients were in their fifth decade, representing a sharp

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rise in the incidence of osteoarthritis. The number of patients in their sixth decade was 23 (23 per cent), which is considerably less than the number in their fifth decade but considerably greater than that in the fourth decade. Twenty-two (22 per cent) of the patients were in their seventh decade, essentially equal to the number in their sixth decade. One patient was 81 years of age. The remaining four patients (4 per cent) were under 40 years of age; two of them being 34 years of age and two of them, 36 years of age. These data are illustrated in Figure 1.

Sex. An analysis of the 100 cases of osteoarthritis reviewed reveals that 73 (73 per cent) of the patients were female and 27 (27 per cent) were male, a ratio of almost three females to one male (Table 1). If, as I am inclined to believe, this group of cases represents a cross section of the general population, it would appear that the incidence of osteoarthritis is considerably higher in females. This observation lends considerable support to the notion that physical exertion does not predispose one to osteoarthritis, since it is generally agreed that men are more likely than women to be engaged in strenuous physical activity. There are, of course, notable exceptions to this statement.

TABLE 1

Osteoarthritis: 100 Cases

Sex	Number	Per cent
Female	73	73
Male	27	27

Joints. It is interesting that in slightly over half (53 per cent) of the patients in this series the osteoarthritis involved only one area (Table 2). In these patients the joints involved, in order of frequency, were as follows: knees, 19; spine, 17 (lumbar, 8; cervical, 6; and thoracic, 3); hips, 9; fingers, 6; shoulders, 1; and great toe, 1 (Table 3). In each of the remaining 47 patients (47 per cent) the disease involved more than one area, for example, the hands, hips and knees or various other combinations of joints. However, when multiple joints were involved in one patient, his symptoms usually were most pronounced in one.

TABLE 2

Osteoarthritis: 100 Cases

Joints	Number	Per cent
Single	53	53
Multiple	47	47

TABLE 3

Osteoarthritis Involving Single Joints

Joints	Number	Per cent
Knees	19	36
Spine*	17	32
Hips	9	17
Fingers	6	11
Shoulders	1	2
Great toe	1	2
Total	53	100

*Lumbar 8, cervical 6, thoracic 3

TABLE 4

Osteoarthritis: 100 Cases

Weight	Number	Per cent
Overweight	50	50
Normal	50	50

TABLE 5

Osteoarthritis Involving Weight-Bearing Joints

Weight	Number	Per cent
Overweight	47	70
Normal	20	30
Total	67	100

Weight. Obesity long has been considered of importance in the incidence of osteoarthritis. However, it would appear to be of little significance when one considers the whole problem

of osteoarthritis. For example, of the 100 patients included in the present study, 50 (50 per cent) were considered to be overweight, while an equal number were considered to be of either normal or less than normal weight (Table 4). Further analysis of these 100 patients revealed, however, that the osteoarthritis involved weight-bearing joints (hips and/or knees) in 67. Of these 67 patients, 47 (70 per cent) were definitely overweight, as compared to 20 (30 per cent) whose weight was considered normal for their age and height (Table 5).

Anemia. The presence or absence of anemia is an extremely important consideration in the differentiation between rheumatoid arthritis and osteoarthritis. In the former, anemia is a common finding; in osteoarthritis, anemia is not the rule. The hemoglobin determination was 12.0 gm. or more in 85 per cent of the 100 cases in this survey. It was 11.5 gm. or more in 97 per cent. In other words, the hemoglobin determination was less than 11.5 gm. in only three cases (Table 6).

TABLE 6

Osteoarthritis: 100 Cases

Hemoglobin (gm.)	No.	Per cent
12.0 or more	85	85
11.5 or more	97	97
Less than 11.5	3	3

Sedimentation Rate. It is my opinion that, aside from the typical appearance and symptomatology of the joints involved, the erythrocyte sedimentation rate is the most important diagnostic aid in differentiating between rheumatoid arthritis and osteoarthritis. In rheumatoid arthritis the sedimentation rate practically always is elevated, at least to some degree, whereas in osteoarthritis it usually is within normal limits or only slightly elevated.

The erythrocyte sedimentation rate was performed in 98 of the 100 cases in this survey (Table 7). In 66 (67.3 per cent) of the 98 cases it was within normal limits. In the remaining 32 cases (32.7 per cent) the sedimentation rate was elevated. However, it exceeded 50 mm. per hour (Westergren method) in only 10 cases (10.2 per cent of the 98 cases in which it was done.). Of the 10 patients with osteoarthritis whose sedimentation rates exceeded 50 mm. per hour, four had unmistakable evidence of the mixed type of rheumatoid arthritis and osteoarthritis, one also had periarteritis nodosa, one had acute diverticulitis, one had a severe debilitating fibrositis, and one had an acute respiratory infection.

In only two of the 10 cases in which the sedimentation rate exceeded 50 mm. per hour was the elevation unexplained. In other words, if one has under observation a patient who appears to have typical osteoarthritis and whose sedimentation rate is elevated above 50 mm. per hour, one must immediately search for some other associated disease to explain it.

TABLE 7

Osteoarthritis: 98 Cases

Sedimentation rate (Westergren)	No.	Per cent
25 mm./hr. or less	66	67.3
26 to 50 mm./hr.	22	22.5
Over 50 mm./hr.	10*	10.2

*In 8, associated disease.

Symptomatic Arthritis

From time to time those interested in rheumatology will be consulted concerning a type of arthritis which is not the primary cause of the patient's disability, although joint pain may be the symptom that has prompted the patient to seek medical care. This type of monoarticular or polyarticular arthritis often occurs as a manifestation of serious systemic disease and therefore belongs in the category of symptomatic arthritis. The so-called collagen diseases, namely, lupus erythematosus, periarteritis nodosa, scleroderma and acrosclerosis, are examples of this.

There are a number of other diseases such as erythema nodosum, allergic states and the rather unusual arthritis associated with psoriasis, in which the patient's primary complaint

may be referable to the joints. Symptomatic arthritis also may occur as a manifestation of certain infectious diseases, including gonorrhea. During the five-year period ending July 1, 1959, we observed 17 examples of this type of joint disease (Table 8). These will be discussed separately.

Lupus erythematosus. During the five-year period the diagnosis of lupus erythematosus was made in five patients. In all of them, severe and at times disabling symptomatic arthritis was observed. In contrast to osteoarthritis, this disease is more likely to occur in patients in the younger age group. The ages of these five patients were 27, 29, 30, 33 and 59. There is nothing characteristic about the pain or joint distribution. However, it is likely to simulate that due to rheumatoid arthritis. The patients characteristically have leukopenia, anemia and markedly elevated sedimentation rates (often 90 to 100 mm. per hour by the Westergren method or higher). Sensitivity to sunlight also is an important associated symptom.

Periarteritis nodosa. During the period covered in this survey the diagnosis of periarteritis nodosa was made in a total of six patients seen in the Lexington Clinic. In three of these patients symptoms and findings referable to the joints occurred. In other words, symptomatic arthritis was a prominent symptom in only 50 per cent of these six cases. The prominent features of periarteritis nodosa include multiple involvement of different systems, particularly neurologic manifestations, and as a rule, findings in the urinary tract. These patients usually have very high sedimentation rates. The final proof of diagnosis usually rests on biopsy or material obtained at the time of postmortem examination.

Scleroderma and acrosclerosis. During the five-year period we had occasion to observe two patients whose primary complaint was swelling and stiffness of the joints and in whom the primary disease was found to be scleroderma. There also was one patient, a 54-year-old white male, whose primary disease was classified as acrosclerosis. Characteristically, the difficulty with the joints in these types of lesions is marked thickening of the skin and subcutaneous tissues with associated paresthesias and Raynaud's phenomenon.

Erythema nodosum. While joint involvement is not common in erythema nodosum, on occasion the joint pain may be the patient's primary concern and the symptom which prompts him to seek medical care. In fact, the patient may not even be aware of the lesions present, usually, on the anterior surface of the lower extremities. During the period covered in this survey, the diagnosis of erythema nodosum was made in 14 cases. In only three of these were the patients' predominant complaints referable to the joints. In one of these cases the monoarticular arthritis was the primary finding and the lesions of erythema nodosum did not appear until a number of days after the onset of the joint complaint. One helpful associated finding in the diagnosis of erythema nodosum is the fact that a fairly large percentage of patients with this disease will be found to have enlargement of the mediastinal lymph nodes.

TABLE 8

Symptomatic Arthritis

Diagnosis	No. of cases
Lupus erythematosus	5
Periarteritis nodosa	3
Scleroderma	2
Acrosclerosis	1
Erythema nodosum	3
Psoriasis	2
Gonorrhea	1

Psoriasis. While the joint manifestations of lupus, periarteritis, scleroderma and erythema nodosum are likely to resemble those of rheumatoid arthritis, symptomatic arthritis associated with psoriasis is more likely to resemble osteoarthritis involving the terminal metacarpal and metatarsal joints. Although psoriatic arthritis is indeed uncommon, it is nevertheless a well recognizable disease. Pain, swelling and deformity in the distal joints of the hands and feet in a patient who has psoriasis are very likely to be psoriatic arthritis. During the five-year period we had occasion to observe two

patients who had typical psoriatic arthritis. One was a 68-year-old male and the other was a 38-year-old female. Prompt improvement in the joint symptoms in these patients usually will occur after effective therapy of the psoriasis.

Gonorrhea. During the last five years we have had occasion to observe only one example of gonorrheal arthritis. This type of arthritis is usually monoarticular. Its final diagnosis depends on the isolation of Neisseria gonorrhea from the fluid removed from the joint. Usually there is considerable synovial reaction with joint fluid. The history of urethritis is usually a clue to the diagnosis, although the joint manifestations may occur some time after the primary urethritis. Since the advent of modern chemotherapy, gonorrheal arthritis has become indeed uncommon.

Comment. There are other forms of symptomatic arthritis, including septic arthritis. In the true sense of the word, gouty arthritis is simply a joint manifestation of a systemic metabolic disease.

Although rheumatoid arthritis and osteoarthritis are the forms of arthritis most often encountered by the clinician, he will do well to remember that joint pain and swelling may be symptoms of many other, at times serious, systemic diseases. The important question to be answered by the clinician is not simply "Does the patient have arthritis?" but "What kind of arthritis does the patient have?"

Summary

Osteoarthritis is the commonest form of arthritis encountered by those interested in rheumatology. This report deals with an analysis of 100 cases of this type seen on one of the medical services at the Lexington Clinic during a five-year period. Osteoarthritis is more likely to occur in the fourth, fifth and sixth decades of life, whereas rheumatoid arthritis is more likely to occur in the earlier decades.

In this series of cases osteoarthritis was observed three times more frequently in females than in males. In slightly over half of cases osteoarthritis involves a single joint. When multiple joints are involved, the symptoms usually are more pronounced in one joint. Obesity does not appear to be an important factor in osteoarthritis, except when the weight-bearing joints are involved. Anemia is rare in osteoarthritis.

The sedimentation rate is of great value in the differential diagnosis. In well over half of patients with osteoarthritis the sedimentation rate will be found to be within normal limits. It may be slightly elevated in the remainder. If the sedimentation rate exceeds 50 mm. per hour by the Westergren method, there usually is some other associated disease present which accounts for its elevation.

During the period covered by this survey, 17 examples of symptomatic arthritis have been observed. In these cases the arthritis was a symptom of other, often serious, disease. It is imperative that the clinician recognize and treat the primary disease in such instances.

Office Diagnosis And Treatment In Proctology*

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The common anorectal diseases—hemorrhoids, abscesses, condylomata acuminata, fissure, pruritus ani, papillae, polyps, coccygodynia—are discussed. Mistakes are emphasized

Introduction

THE conditions which cause rectal symptoms are encountered at one time or another by almost all doctors, whether they are in general practice or in a specialty. A sympathetic and understanding attitude will encourage the friendship of the patient whether or not treatment is given. If a doctor can guide the patient in his investigation or give him relief from his pain, he will have a friend.

Many patients are handed a sample box of suppositories after a brief history has been taken and no examination has been made. This antagonizes the patient and in some cases delays treatment of cancer of the rectum or sigmoid.

Examination

The patient may be placed in a left lateral Sims' or a knee-chest position or simply in a prone position, that is, flat on the abdomen with a pillow or blanket roll beneath his hips to elevate the buttocks. If the patient spreads his legs apart, a better view of the anus is obtained and a forceful retraction of the buttocks is not necessary. A glove or finger cot, lubricating jelly and a gentle touch, slowly applied, are other essential factors. Any sudden moves or rough pulling will quickly put the patient to working directly against the examiner and a tug of war begins.

To see the inner part of the anal canal and internal hemorrhoidal area, the use of an anoscope is necessary. A digital examination and anoscopic examination should always be made by the examining physician. The use of a 10 inch (25 cm.) sigmoidoscope requires more time and practice. If the doctor does not elect to use the sigmoidoscope, he should refer patients for such examination when the symptoms suggest a lesion higher in the rectum.

With the sigmoidoscope one can diagnose more than 25% of ulcerative colitis cases, 75% of the polyps of the colon, and at least 70% of the cancers of the colon. Many doctors include sigmoidoscopy in the complete, routine physical examination of patients over 50 years of age because of the high incidence of polyps in this age group.

External Hemorrhoids

The thrombotic external hemorrhoid is most frequently seen in the office. The history is of sudden onset of severe, constant, perianal pain. A palpable, hard, bluish swelling or lump can be felt in the anal canal. If the thrombus and protrusion involves the entire circumference of the anal canal, no office treatment should be attempted, for this is a hospital case.

In the majority of cases, the thrombosed external hemorrhoid is small and, after a local anesthetic, the roof of the swollen area should be excised. The old procedure of lancing or making a small incision in the crown of the thrombus and evacuating the clot should not be done. The small incision quickly closes and the thrombus forms again in a few hours, thus causing more pain and making two operations necessary.

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Internal Hemorrhoids

The nonprolapsing type of hemorrhoids with bleeding may be treated by injection. Briefly, the injection treatment of internal hemorrhoids consists of the use of a 5% solution of quinine and urea hydrochloride. Before the use of this substance, a history is obtained as to whether the patient is sensitive to quinine. Good results may also be obtained with 5% phenol in oil, which may be used if the patient is sensitive to quinine. For the injection of internal hemorrhoids, a Barr-Shuford speculum is usually used. A 20 gauge BD hemorrhoidal needle on a small syringe or the regular needle that is used for the local anesthesia for tonsils can be used.

The anoscope is inserted to above the pectinate line. The internal hemorrhoids are visualized and swabbed with an antiseptic solution. The sclerosing solution is then injected at the highest and most accessible or superior pole of the hemorrhoid, using ½cc. of the sclerosing solution. It is definitely best to start off with only a small (⅛ to ½cc.) injection in one area until you determine how sensitive the patient is to the solution. Usually there will be three or four hemorrhoids, and these should be injected at approximately one-week intervals, injecting one hemorrhoid at one office visit.

Injections

The injection should always be placed above the pectinate line and underneath the mucous membrane covering the internal hemorrhoid. If the injection is too close to the pectinate or anorectal line, there will be a severe pain which is very disturbing. One can immediately inject 2cc. of procaine solution into the painful area at the anorectal line, or hot baths will usually relieve the pain. The injection of the solution should never be carried to the point of blanching of the mucous membrane because necrosis is apt to result.

Injections should never be placed into hemorrhoids which are acutely inflamed, ulcerated, or thrombosed. One should never inject through the skin and never inject external hemorrhoids. The injected area should be palpated at each visit. If there is induration and hardness in the previously injected hemorrhoid, the injection should not be repeated until the hemorrhoidal area becomes soft.

The prolapsing type of hemorrhoids should be treated by surgery and not by office treatment.

Strangulated hemorrhoids require surgery. If these hemorrhoids reduce easily, it is best to reduce them, but if thrombosis and especially if ulceration or necrosis has taken place, it is best not to do anything until the patient is under anesthesia in the hospital. One bad mistake, which is often made, is to try to force them back into the rectum.

Abscess Of Anorectum

One should think in terms of abscess below and abscess above the levator ani in the diagnosis of abscesses of the anorectum. Most abscesses of the anorectum are the acute exacerbation of a chronic cryptitis, extension of a fissure or a fistula whose internal and external openings have been occluded. The symptoms are a continuous, throbbing, anorectal pain with a localized, red, tender and indurated swelling. The temperature may be elevated, and leucocytosis and increased pulse rate may be present. The diagnosis is confirmed by inspection, and digital examination.

The abscess should be incised and drained immediately. Too often, doctors want to wait until the abscess localizes or points. This is a definite mistake. The fatty tissue in the ischiorectal area makes an excellent medium for the infection to spread rapidly and widely, and abscesses in this area do not localize.

Incising and Draining

Too frequently, penicillin is given with the hope that the abscess will disappear. This will seldom occur without adequate drainage. Incision and drainage of many of the abscesses may be done in the office; it is usually done with the patient under a local procaine infiltration anesthesia. A good rule to follow for office drainage is to do those abscesses which are just underneath the skin. A person with an abscess that is high or in a submucosal area inside the rectum or above the levator muscles should be treated in a hospital and not in the office.

When incising and draining the abscess, it is best to stay as close as possible to the anorectal outlet and make a cruciate incision; then, with the scissors, cut out each corner, leaving a

large, circular hole. The worst mistake that a doctor can make is to lance the abscess and leave only a tiny opening. This quickly closes and the pus accumulates again; thus, the patient is in trouble all over again. After incision and drainage of the abscess, the patient may be sent home with a sedative and started the next day on hot sitz baths.

The doctor should always tell the patient at the time of the incision and drainage that this will relieve his pain but that it will not cure the fistula-in-ano which is the main cause of his trouble.

In examining a patient with an abscess of the perianal region, one should always look for the misleading or unusual conditions such as hidradenitis or an abnormally placed pilonidal cyst. It is best not to probe the abscess at the time of incision and drainage. A probe should be used at the time of surgery in the hospital to determine the extent of the fistula and also whether it is an unusual condition such as mentioned above. The treatment of a fistula-in-ano is a hospital procedure and will not be discussed here.

Condylomata Acuminata

Usually, condylomata acuminata (venereal warts) are seen growing in the very moist places in the perianal region. It is best to take a biopsy to determine the exact nature of the condition and to use the Kahn test to distinguish them from condyloma latum. They are usually easily destroyed by fulguration but have a high rate of recurrence. The patient should be told that they may come back.

Some physicians prefer to use podophyllin preparations rather than fulguration, but they must be used with a great deal of care. Most doctors prefer to use a fulgurating unit in the office to remove the warts. Some use phenol on a sharpened applicator stick, being careful not to touch any but the desired areas and then carefully drying away any excess phenol.

After the warts are removed it is essential to keep the area dry. Boric acid powder, corn starch, or baby talcum powder may be used for this purpose. If the warty excrescences are extremely large or completely surround the anal canal, it is best to hospitalize the patient and do a complete excision and fulgurate the base of the excised warts.

Fissure of Anus

Anal fissures, for the purpose of treatment, may be divided into the superficial, which is a small split or tear in the perianal skin and is often referred to as the acute fissure, and the chronic fissure, which is undermined and fibrotic and has a large external skin tag and internal hypertrophied anal papilla. Both the patient and the doctor will be happier if treatment of the chronic fissure is done in the hospital and not in the office.

The patient with the acute fissure complains of severe pain with bowel movements and often has a continuing burning or aching after the bowel movement. There may be a history of recurring constipation and streaking of blood on the well-formed or hard bowel movements. The blood is usually seen on the toilet paper only but may occasionally be explained by the patient as a drop or two of blood passing with the bowel movement. On separating the buttocks, the examiner sees a raw, red split at or just inside the anal verge. An acute fissure responds well to office treatment, but the patient should be warned that, if he neglects his regular bowel habits and allows himself to remain moist or dirty, the fissure may go on into the chronic phase.

Treatment usually consists of having the patient wash the anus after each bowel movement and apply a 1% cortisone ointment locally. I also advise use of a local analgesic ointment before bowel movements.

Pruritus Ani

Several books have been written on pruritus ani, which is usually described by both patient and doctor as being a terrible condition. One can quickly and definitely determine how severe the case is by asking if the itching is worse at night. In the patients who remain awake at night, the itching is definitely more severe and responds less to treatment.

Briefly, the classification, description and therapy of the usual types of pruritus ani is as follows:

(1) *The fungus type* is usually seen as a papulomacular moist dermatitis, with ring formation around the anal orifice. Treatment consists of painting the perianal area with carbolfuchsin three times weekly or using

a fungicide ointment. Potassium permanganate sitz baths are also helpful for this particular type.

(2) *The intractable type* is a lichenification with erosion close to the anal opening. Office treatment consists of painting the perianal skin with a tannic acid or potassium permanganate solution.

(3) *The neurogenic type* is a well-localized patch of perianal dermatitis. Application of a saturated solution of potassium permanganate is used.

(4) *The simple type* includes all the miscellaneous types, such as those associated with fissure-in-ano, fistula, postoperative wounds, antibiotics, amebic colitis, and diarrhea. This type is treated by removing the etiologic factor or by anorectal surgery, or by treating the cause with a specific medicine when possible.

(5) *Pinworm pruritus ani* is diagnosed by the history and demonstration of the pinworms at anoscopic or proctoscopic examination. A Scotch-tape method of examination may be used to determine the presence of pin worms, but this is usually not necessary. The treatment consists of removing the parasites by use of specific drugs.

(6) *Dermatitis venenata* follows the use of some anorectal ointments or allergenic foods. In treatment of this type of pruritus, antihistamines are given orally and use of all ointments and salves is stopped. Continuous wet dressings are applied, using one part of Burrow's solution to 10 parts of water or equal parts of witch hazel and water. The patient is given a sedative so that he can sleep at night. The application of the wet dressings keeps him busy in the daytime and keeps him from scratching.

There are many more general causes of pruritus ani, such as diabetes mellitus and different contact allergies, which are helped by treating the general medical problem and by advising the patient to keep the anal skin very clean and sponge and blot and wash, instead of wiping, the perianal skin. The patient should be instructed to dry with a piece of cotton and even wear a piece of cotton between the buttocks to absorb moisture during the day.

Suppositories are mentioned here only to advise against their use, especially the most popular one of belladonna and opium. Belladonna has no local action and opium is not a local anesthetic.

The anesthetic ointments, and all the salves and various agents on the market that are used by both doctors and layman, are a *"snare and a delusion."* They carry a definite danger of sensitizing the patient to a great number of medications and frequently increase the itching.

In the chronic cases of pruritus ani that result in some of the cases described above, one may apply local antiseptics in aqueous or alcoholic solutions in the office. Five per cent aqueous solutions of mercurochrome or gentian violet may be used; or, in some cases, a saturated solution of potassium permanganate. A solution of equal parts of camphor and phenol has been used in some cases with good response. One of the above solutions is applied each time the patient visits the office.

The patients are instructed to wash with plain water after each bowel movement and not to use soap. Many are relieved by sponging the area four to six times a day with witch hazel. An aluminum hydroxide mixture such as Amphojel® is often helpful when applied locally.

Hypertrophied Anal Papillae

Frequently a patient is referred with the diagnosis of a rectal polyp which is actually a papilla. A papilla arises from skin at the pectinate line, but it may remain inside the rectum. It is hard, sensitive, white and pointed. It may later become rounded at the tip and even become papillomatous. It rarely, if ever, becomes malignant; as compared to the rectal polyp, which is soft, insensitive, pink to red, arises from mucosa, and becomes malignant in a large number of cases. Treatment consists of local anaesthesia and excision of the papilla. The size of the papilla and the presence of adjacent anorectal pathology may require hospitalization.

Rectosigmoidal Polyps

The diagnosis of rectosigmoidal polyps is made by seeing them on sigmoidoscopic examination. The treatment of polyps depends on their size and location. Very small sessile or pedunculated, benign, adenomatous polyps

may be destroyed by fulguration without undue danger or complications.

Larger pedunculated and sessile, benign, adenomatous polyps can be safely fulgurated if they are below the peritoneal reflection or on the posterior wall of the rectum. Large, sessile, adenomatous polyps should be subjected to more radical treatment, and numerous biopsies should be made. Pedunculated, adenomatous polyps of a larger size may be fulgurated if they are noninvasive and easily reached.

Routine proctosigmoidoscopy should be a part of all general physical examinations because of the frequent finding of adenomatous polyps. All patients in whom a polyp has been found should have a complete and thorough examination of the colon and rectum, including barium enema with air-contrast studies. Repeat examination each year, including x-rays of the colon and proctosigmoidoscopy, is mandatory once a polyp has been found in the rectum or lower sigmoid.

All polyps above the peritoneal reflection should be excised in the hospital and either colotomy or segmental resection should be performed.

Coccygodynia

In coccygodynia the patient complains of pain in the vicinity of the coccyx and adjacent regions and in the sacrococcygeal joint, back and buttocks. Sometimes the pain may extend down the back of either the right or the left leg. Coccygodynia or "television-bottom" has been attributed to neuritis, neurosis, neuralgia, rheumatism, strain, luxation and fracture. Treatment has included sedatives, antineuritics, antispasmodics, rectal suppositories, hot and cold applications, electrotherapy, massage of the coccyx, radiation therapy and even coccygectomy.

The most effective treatment has been massage of the spastic and tender levator ani and coccygeus muscles. The use of hot sitz baths and the use at night of an electric hot pad with a stable temperature has sometimes proved effective. The etiologic factors, such as an infection in the prostate or the epididymus or in the cervical or anal regions, can be removed in some cases. Elimination of anorectal pathology when present also helps the treatment.

The patient is instructed in regard to posture. A special effort is made to teach him to lean forward and to sit well back on a hard chair, so as to remove pressure from the coccyx and the sacrococcygeal joint. Surgical removal of the coccyx has been condemned as the treatment for coccygodynia, except in very rare instances.

Summary

The diagnosis and treatment of the common anorectal diseases are discussed.



Management Of Allergies With Emphasis On Asthma*

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The management of bronchial asthma is difficult under any circumstance. However, much can be done to afford relief of symptoms. Partical suggestions are discussed in detail

THE management of allergic diseases may be considered from three viewpoints. The first, immunologic or specific therapy, consists of immunization against the allergens. This is primarily the province of the allergist and is used after the causative allergens are determined. The second is the elimination or avoidance of the allergens. The third, which the generalist can use to good advantage, is symptomatic treatment. The major portion of this paper is devoted to this aspect of therapy.

To determine which antigens produce symptoms, one must take a thorough history, examine the affected areas and do indicated laboratory procedures, including allergy tests. The test most often used by the allergist is the skin test. Although this is an important diagnostic method, too often the patient has the erroneous impression that he is consulting the allergist only for skin tests rather than for allergy studies.

The specialty of allergy has progressed far beyond dependence upon skin tests for diagnosis. There are a dozen or more methods of allergy testing, including the mucous membrane test, conjunctival test, sniff test, passive transfer tests, iontophoresis test, ingestion test, trial diet and the environmental test. Many of these tests are simple and easily done.

Skin tests are performed by the patch, scratch, puncture and intradermal technique to demonstrate the antigen-antibody reaction. There are precise indications for the employment of any particular type of test. The correct utilization and interpretation of the indicated tests help to determine the etiologic allergens.

Treatment

Immunologic therapy can be used when the offending allergens are known. This is called desensitization or hyposensitization and consists of stimulating humoral antibodies which will neutralize the antigens at or before they reach the shock tissue. This is specific treatment.

Perhaps more important than hyposensitization, but frequently difficult to attain, is the avoidance of allergens. If this, or the complete removal of the offending allergen could be accomplished, there would be little need for specific or symptomatic treatment. Except for pollen sensitivity, which can be resolved by moving to a pollen-free area during the provoking pollenating season, allergenic exposure can be only modified. Even so, avoidance of exposure to allergens is important in management because it may lessen symptoms, increase the development of further allergic resistance and possibly allow some natural immunity to develop. The thoroughness with which this regimen is enforced may spell the difference between success or failure in reducing allergic manifestations.

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No matter what the patient may do regarding the first two measures of treatment, he usually complies with the third part of allergic management, which is symptomatic treatment and is the most realistic to the patient who needs relief. Symptomatic treatment should relieve allergic symptoms but too often the medications are directed with "shotgun" inaccuracy. There is no justification for indiscriminately giving ACTH or corticosteroids to an allergic patient every time he walks into the office with a wheeze, sneeze or itch.

It is difficult to choose the most effective medication among all those available. The practitioner should select a few which best meet his requirements and become familiar with these. Many of these drugs have the same pharmacologic action. Furthermore, some of the old drugs and remedies are effective in certain allergic diseases.

Secret to Success

The secret to the success of symptomatic therapy, if it can be called a secret, is to know the patient and to know the disease. In the latter instance, the specialist may have some advantage over the family doctor. On the other hand, the family doctor understands the patient better and often can pin-point the most annoying of his patient's symptoms and thereby be more precise and practical in prescribing therapy. The allergist may direct the patient to make his bedroom allergy-free but it is the family doctor who visits this patient at the sick bed and can see at first hand whether he has followed the recommendations such as encasing the feather bed or placing a filter in the window during the pollen season.

If the attending physician will obtain an informative history and examine the patient, he should have no difficulty in diagnosing allergic illness. If he also considers the pathophysiology producing the symptoms, then prescribing the best medication should be relatively easy. It is when symptomatic medication is ineffectual or not tolerated, or when the disease becomes chronic and complicated, that the allergist should be consulted.

The simplest approach to effective symptomatic treatment of allergies is thorough knowledge of cellular pathophysiology and the pharmacology of anti-allergic medications. This is one reason it is necessary for the practitioner to have a clear concept of a few anti-allergic medications which he can utilize most effectively.

Pathophysiology

It has been said that to know bronchial asthma is to know allergy. To express it somewhat differently, the basic alteration in sensitivity which we designate as allergy is fundamentally similar irrespective of whether it occurs in the nose, eye, bronchus, skin or in any other shock tissue. However, there is considerable dissimilarity in the presenting symptoms because of the difference in the anatomy of the affected tissue.

Briefly, the essential histopathologic changes consist of edema, smooth muscle spasm, increased mucus and eosinophilia. The vascular bed in the affected area is the primary target tissue.

Symptomatic Treatment of Bronchial Asthma

Acute Asthmatic Attacks—

As a rule, the average uncomplicated paroxysm of bronchial asthma can be aborted or relieved by epinephrine or comparable sympathomimetics. Aqueous epinephrine (1-1000) in doses of 0.15-0.25 cc., repeated every 10 to 15 minutes for three to four times if necessary, is by far the drug of choice for acute attacks except in those patients who become "epinephrine-fast." This condition usually results from too frequent self-administration of Adrenalin® injections or an over indulgence in nebulization with epinephrine-like solutions. When Adrenalin-fastness is suspected, aminophylline injected intravenously in doses of 0.25 to 0.50 Gm. (3¾ to 7½ grains) usually will stop the attack. Aminophylline must be administered very slowly and it should take at least ten minutes to inject a 10 cc. ampoule.

If the attack is not too severe or acute, one of several available oral preparations can be given. Practically all of these proprietary combinations contain ephedrine sulfate, theophylline or aminophylline and a barbiturate. Some of these preparations also include potassium iodide. A few are marketed with a coating of nor-epinephrine so that sublingual or buccal use enhances absorption for immediate relief, the inner core of the tablet being swallowed

and absorbed more slowly to produce prolonged action.

Recurrent or Sub-Acute Bronchial Asthma—

This situation requires a somewhat long-range type of program. Oral medication may have to be taken with greater regularity to prevent attacks or to keep them under better control. Iodide in one form or another has been employed for many years in the treatment of asthma and it still is one of the most effective mucolytic agents. Potassium iodide, given orally and preferably as the saturated aqueous solution, in doses of 10-15 drops, three to four times a day, ordinarily suffices. The action of iodides is not completely understood, but they are believed to be eliminated in the tracheo-bronchial secretions which they liquefy and render less tenacious, as well as by reflexly increasing the flow of mucus via a vagal pathway through gastric irritation.

Mucolytic Agents

Because the mucus in bronchial asthma either is so excessive it fills the bronchial tree or is so gelatinous it plugs the bronchioles, producing obstructive emphysema, it is essential to remove this obstruction. If the iodides are not tolerated, ammonium chloride in doses of 0.5 to 1.0 Gms., three to four times a day, will help to liquefy the mucus. When the cough reflex is absent or diminshed, syrup of Ipecac in a sub-emetic dose often will produce bronchiolar evacuation. Numerous cough expectorants are available to aid bronchial drainage. One of the most important mucolytic agents which isn't employed often enough is an adequate fluid intake. It is axiomatic that one cannot liquefy without liquids. During an asthmatic episode considerable water is lost through perspiration and expiration and unless this fluid is replaced, dehydration will result which contributes still further to the inspissation of the mucus.

More frequent and regular use of oral preparations such as aminophylline and ephedrine, which open the bronchial airway, usually helps to prevent the development of severe, acute paroxysms of bronchial asthma or status asthmaticus.

The importance of rest should not be minimized. This includes the avoidance of repeated crises in the home or at work. The asthma-prone patient who continues to lose sleep every night soon feels harrassed, becomes increasingly tense and gradually finds himself in a downhill spiral which ends in an acute or refractive state of bronchial asthma. Theoretically, the tranquillizing agents should be ideal in these situations but in general these drugs have been disappointing in our experience.

Barbiturates and chloral hydrate usually provide the greatest relief but these should be used judiciously. If the asthmatic patient can be given some insight into his problem, and if he can be taught some self-discipline such as proper breathing technique whenever asthma threatens, he often can abort a severe attack.

Status Asthmaticus—

The most commonly accepted definition of status asthmaticus implies an epinephrine-fast or epinephrine-resistant bronchial asthma. Status asthmaticus often results from too frequent and indiscriminate use of epinephrine or similar medication in one form or another.

Many factors contribute to the development of this serious complication of bronchial asthma and if it is not ended by appropriate measures, it frequently will terminate fatally. Any physician who treats an asthmatic patient who is in status must be alert to this dangerous situation and should utilize every resource to prevent a fatal outcome.

The recognition of all factors which contribute to this jeopardous state of affairs is half the battle. These pathophysiologic alterations may include dehydration, hypoxia, hypercapnia, hypoglycemia, respiratory acidosis, toxemia and adrenal exhaustion. Clinically, the patient is frightened, pale and perspiring profusely. He sits up, fights for every breath with all his accessory respiratory muscles and wheezes audibly. This patient desperately wants and needs help.

The attitude and bearing of the physician when attending the patient may significantly affect the outcome of the attack. A calm, confident bearing is important and is reassuring to the patient who is apprehensive, wary and sensitive to every act, expression or statement pertaining to him. The nursing care should be performed with a quiet, efficient manner.

If the patient is cyanotic or has some com-

plicating pathology such as cor pulmonale, oxygen should be administered by the most appropriate method with care to avoid a too high concentration. Helium-oxygen mixture, frequently recommended, is seldom available. Oxygen usually can be discontinued after 24 to 48 hours if the patient responds to other therapy, but it may be wise to keep the tent close at hand an extra day or two for reassurance.

Parenteral Fluids

Dehydration is best treated by parenteral fluids, preferably intravenously although it may be necessary to give it subcutaneously to an infant or small child. As a matter of fact, it is mandatory for the infant or child with status asthmaticus to receive parenteral fluids. It is always safe to begin the infusion with 5% glucose in water. A 1000 ml. flask is used except for the pediatric age group. It usually is given at a rate of about 20 to 30 drops per minute unless ACTH is included.

After the infusion has been started, other ingredients necessary to relieve the patient and counteract the altered physiology can be added. We refer to this infusion mixture as the "I. V. cocktail." Fluid intake should be forced by mouth in addition to that given parenterally. The respiratory acidosis which freqently accompanies prolonged asthma, particularly in the pediatric group, can be combated by the use of Polysal® or 1/6 molar lactate. About 20 ml. per pound of body weight is the amount of parenteral fluid administered with the first flask.

Aminophylline

Aminophylline in a dose of 0.5-1.0 Gm., should be added to the infusion first. This is one of the most efficacious bronchodilating agents for epinephrine-fast bronchial asthma. It has the additional advantage of being safe in the event the patient has cardiac as well as bronchial asthma. Another trick to remember, particularly if the patient is in extreme distress, is to inject a separate ampoule of aminophylline directly into the lower end of the tubing. This will usually alleviate the symptoms quickly, even if only temporarily.

One ampoule of sodium iodide, which is available as 1 Gm. in 10 cc. of distilled water is next added to the infusion. At the same time the patient should be started on iodides by mouth, preferably as the saturated solution, in doses of 10-15 drops every four hours. SSKI taken orally often is as effective almost as rapidly as sodium iodide given intravenously by slow drip.

Frequently the patient in status seems unable to cough, or his cough is ineffective in ridding the bronchial tree of mucus. Unless this predicament is corrected, respiratory function will be embarrassed and until the fluids and iodides have time to liquefy the mucus plugs, other measures may become necessary. Syrup of ipecac in sub-emetic doses given separately or with potassium iodide will enhance bronchial lavage. If this expectorant combination fails to initiate a productive cough, it may be essential and wise to bronchoscope the patient. This procedure serves the dual purpose of treatment and diagnosis, and in the former instance often has proved life saving.

Safe Sedatives

Because the patient is exhausted yet unable to sleep, an hypnotic should be added to the cocktail. The barbiturates in proper dosage are quite safe, and for an adult 0.15 Gm. of any of the soluble preparations can be used. Another safe sedative is chloral hydrate which is taken orally in doses of 0.5 to 1 Gm. for an adult. Opiates are ordinarily contraindicated in the management of status asthmaticus or bronchial asthma because they depress the cough reflex and actually may increase the bronchoconstriction. If the mucus is not too tenacious, one of the injectable antihistamines can be added to the infusion. In fact, the antihistamines may help correct the epinephrine refractoriness. If these measures fail to induce sleep, there should be no hesitancy in employing ether as an ether-in-oil enema or by inhalation. The bronchodilating effect of ether enhances its value in situations which warrant its use.

The last medication to be placed in the cocktail, whenever it is indicated, is one of the corticosteroids or corticotropins. Which of these prepartions to use may depend in a large measure upon their previous administration, quantity, and the period of time over which they have been taken. The indication for using

ACTH or corticosteroid depends somewhat on whether the adrenals require stimulation or support. It there is good reason to suspect adrenal exhaustion or atrophy because of long term therapy prior to the onset of the status, it is unlikely that corticotropin would be effective for a while. In fact, the situation may demand relatively large doses of corticosteroid until the patient is out of danger. Then, as the condition warrants, stimulating doses of ACTH can gradually be substituted with the idea of replacing artificial steroids as adrenal function returns. Ultimately, ACTH can be discountined when the bronchial asthma is controlled by other measures.

When ACTH is put into the cocktail, 20 units per 1000 ml. usually is adequate. The drip should be regulated so each 1000 ml. of the mixture will take approximately 18 to 20 hours, thus somewhat simulating physiologic corticotropic stimulation. If corticosteroid therapy is indicated early in the program it can be administered more rapidly. In fact, the initial dose should be injected directly through the infusion tube, which will provide immediate relief. Subsequent administration of steroids orally, intramuscularly or intravenously is contingent upon the patient's condition.

Oral Medications

The intravenous cocktail should be continuous, if possible, until the patient recovers from the status. The contents should be modified as necessary from time to time, and from bottle to bottle, depending upon the patient's response. As soon as safely possible, oral medications, including fluids, should be substituted for parenteral therapy.

Whenever the patient is receiving corticosteroids or corticotropins and has or may have an underlying or smoldering infection, the hormones should not be administered without a "covering" antimicrobial agent. If there is an overt infection present, the appropriate antibiotic will help prevent complications. Another important consideration in hormone therapy is the contraindication for their use in diabetes, peptic ulcer, tuberculosis and osteoporosis. A salt-free diet must be maintained during the administration of these hormones.

Chronic Bronchial Asthma—

This is one of the most treacherous types of bronchial asthma. The damage inflicted upon the individual who suffers from this condition is usually insidious. Over a period of time it gradually contributes to or produces most of the serious complications of bronchial asthma, such as emphysema, fibrosis, bronchiectasis and cor pulmonale.

To moderate the progression of the disease, one must thoroughly investigate all etiologic factors. The best treatment is the mitigation of these factors, and not until this has been done can prolonged amelioration of the disease be expected.

One of the most distressing symptoms is dyspnea from obstructive emphysema, resulting from the reduction of the bronchial lumina by increased mucus, edema of the mucous membrane, hypertrophy of the musculature and bronchial spasm. Thus, if all the extrinsic factors can be controlled, symptomatic treatment resolves itself to counteracting the prevailing pathophysiology.

Mechanical Ventilation

Every effort should be made to improve the vital capacity or ventilatory efficiency. In addition to medications, breathing exercises and mechanical ventilation such as IPPB (intermittent positive pressure breathing) frequently are helpful.

As a rule, symptomatic medication should be given regularly rather than periodically, in order to keep the patient comfortable throughout the 24 hours. Mucolytic agents are essential, and in our opinion SSKI is the one of choice. Drugs which produce bronchodilatation and reduce edema are quite effective in the less severe cases and combinations of aminophylline and ephedrine with a barbiturate should be employed. The latter drug serves to sedate the patient as well as counteract the stimulating effect of ephedrine. By using an enteric coated tablet or a suppository containing the same formula, along with the regular tablet or capsule at bedtime, the patient may be insured eight hours freedom from asthma during the night.

The chronic asthmatic individual will resort to anything which offers him immediate relief.

This is unfortunate because it frequently leads to the habitual use of medications which may prove to be more harmful than beneficial over the long haul. The worst in this respect is the self administration of epinephrine or the too frequent use of its homologue in a nebulizer. The former contributes to the development of epinephrine fastness and the nebulizer has the additional disadvantage of becoming a psychologic crutch, which contributes to its over usage.

The chronic asthmatic may become dependent upon the steroid compound. So these preparations should not be used routinely until all orthodox methods of therapy have failed.

Complications of Bronchial Asthma—

The serious complications of bronchial asthma are status asthmaticus, emphysema and cor pulmonale. The first consideration of these conditions is their prevention if possible.

Too often, chronic bronchial asthma begins during childhood and too often it is shrugged off with the statement that eventually the asthma will cease. Regardless of age, when a patient has asthmatic symptoms day in and day out, something definitive should be done about it, otherwise the patient is doomed to become a pulmonary cripple. This does not necessarily mean to tell the patient he has to move to a different climate, blame the attack on nervousness, advise the parents that the child will outgrow it, or prescribe corticosteroids as if they were asperin tablets. Vital statistics show that over 5,000 people in the United States die each year from bronchial asthma and this disease should not be considered lightly.

When the patient does not respond to accepted methods of symptomatic treatment, he should consult an allergist. Even though this is no guarantee that the patient will be cured or the disease arrested, there is no question that a more specific program based upon immunologic principles usually will prove beneficial and perhaps curative. Only after all acceptable measures of therapy have failed should consideration be given to a change in climate or resort to hormone therapy.

When cor pulmonale or pulmonary emphysema become established, treatment is difficult and complicated. These conditions require close supervision and cooperation between the internist, cardiologist, chest physician and allergist. The therapeutic regimen should be outlined in detail, explained to the patient, and made clear for the family doctor who has the ultimate responsibility for carrying out the recommended program.

When these complications develop they may be irreversible. Therefore, the objectives to keep uppermost in mind are to try to prevent the condition from progressing and to keep the patient as comfortable as possible. If the stress is not too great and if the patient can be gainfully employed, he can lead a useful life rather than being relegated to a hopeless future as a chronic pulmonary cripple.

Summary

Bronchial asthma is a prevalent allergic disease. There is much more to learn about asthma and how to prevent and cure it. However, within the past few decades great strides have been made concerning its treatment and amelioration. This paper discusses the rational approach to the symptomatic relief of the various types of asthmatic conditions which confront the practitioner.

CASE DISCUSSIONS
From The
University of Louisville Hospitals

Louisville General Hospital

Bilateral Dermoid Cysts Complicating Delivery

History and Physical Findings

PATIENT PROTOCOL #298929—B.C., a 19-year-old colored primigravida, was admitted to the hospital in early labor on December 19, 1960. Her prenatal course had been normal and her expected date of confinement was November 27, 1960. General physical examination was normal; the abdomen was enlarged to full term size and the fetal heartbeat was normal. By rectal examination the cervix was 3 centimeters dilated, fetal head at station-2, and an 8 X 12 centimeter cystic mass was found filling the cul-de-sac and extending to the left. It was fixed and slightly tender and seemed to be pushing the fetal head anteriorly.

The decision was made to permit the patient to labor for a time to see if vaginal delivery could be accomplished. After two hours, cervical dilatation had progressed to 6 centimeters and the descent to station-1. The cystic tumor was still filling the cul-de-sac, obstructing the descent of the fetal head.

Low cervical caesarean section, therefore, was carried out with the delivery of a term viable infant. Both ovaries contained large cystic masses grossly characteristic of dermoid cysts. The left ovary measuring 12 X 11 centimeters was removed entirely, while the right ovary which contained a 7 centimeter dermoid was preserved by carefully incising the capsule and shelling out the dermoid cyst intact. The defect in the capsule was closed and the remaining ovary was approximately two-thirds normal size.

Postoperative course was normal and mother and baby were discharged on the sixth day. Pathological study showed bilateral dermoid cysts.

Discussion

Dr. Harold W. Baker

This case affords several interesting points for discussion. From the obstetrical side the recognition of a large pelvic mass early in labor was essential for proper management. It was realized that caesaean section might be necessary, and her trial of labor was followed closely to determine if the soft tissue mass would move up out of the pelvis to permit descent of the head. Rectal or sterile vaginal examination of all patients on admission is safe and necessary, except in cases of suspected placenta previa; in these the examination should not be done until blood is cross-matched and the operating room readied for possible caesarean section.

The trial of labor for two hours was worthwhile because some ovarian cysts will rise out of the pelvis as labor progresses, permitting vaginal delivery. This would have been particularly desirable in this case due to the fact that she was a primigravida. The only hazard in permitting the two hours of labor was the possibility of rupture of the cyst by the pounding of the fetal head during contractions. Gentle rectal palpation of the tension of the cyst wall will aid the physician in evaluating this possible danger.

From the gynecological viewpoint, this case demonstrates that pregnancy can occur in the face of good-sized dermoids; these two large cysts were certainly present nine months earlier when she conceived. Unfortunately she did not come to the prenatal clinic until her eighth

month so we do not know how large the cysts were at the time of conception.

Dermoids are benign. Surgically they can be shelled out easily. Among patients in whom bilateral dermoids have been resected and only portions of one or both ovaries preserved, a significant number of patients subsequently have delivered viable infants. Therefore, when the physician encounters bilateral dermoids in a woman who desires future pregnancies, resection of the dermoid cysts should be done.

If the cyst in one ovary is quite large, such as in this case (12 centimeters), perhaps total removal of this ovary is better, but in the medium-sized cysts of 7-10 centimeters, resection can be accomplished with an excellent prognosis for normal ovarian function and pregnancies. Even if the physician cannot recognize any normal ovarian tissue, resection should be done because the thinned-out capsule will contain follicles and will function satisfactorily.

This case illustrates (1) a rather rare complication of pregnancy, a soft tissue mass blocking the canal and necessitating caesarean section, and (2) the important feature of preserving ovarian tissue when bilateral dermoids are encountered in young women.

Manuscript Memos

Manuscripts should be submitted in duplicate to The Journal of KSMA, an original copy and one carbon, and typed with double spacing. Maximum length of an article should not exceed 4500 words; the Board of Consultants on Scientific Articles prefers that they be briefer than this when possible.

In submitting a manuscript, the author is requested to include a concise summary, not to exceed 35 words, to be used as a sub-title when the article is published in The Journal. The purpose of the summary is to create additional interest and encourage greater readership.

Footnotes and bibliographies should conform to the style of the Quarterly Cumulative Index Medicus published by the American Medical Association. This requires in the order given: name of author, title of article, name of periodical, with volume, page, month—day of month if weekly—and year. The Journal of the KSMA does not assume responsibility for the accuracy of references used with scientific articles.

All scientific material appearing in The Journal is reviewed by the Board of Consultants on Scientific Articles. The editors may use up to six illustrations, with the essayist bearing the cost of all over three one-column halftones.

Arrangements for reprints of an article should be made directly with the publisher of The Journal, Gibbs-Inman Printing Company, 817 W. Market St., Louisville, Ky.

The bylaws of the Kentucky State Medical Association provide that all scientific discussions and papers read before the KSMA Annual Meeting shall be referred to the KSMA Journal for consideration for publication. The bylaws further state that the editor or the associate editor may accept or reject these papers as it appears advisable and return them to the author if not considered suitable for publication.

Please mail your scientific articles to The Journal of the Kentucky State Medical Association, 1169 Eastern Parkway, Louisville 17, Kentucky.

SPECIAL ARTICLES

The Osteopathic School of Medicine—Its Doctors And Its Institutions Today In Florida And the U. S.*

IN the State of Florida, 413 doctors of osteopathy practice their profession; this number is approximately 3 per cent of the 13,400 doctors of osteopathy in the United States. The Florida doctors are licensed and regulated under the provisions of the Osteopathic Practice Act and are authorized by statute to have all rights and to be of equal rank and grade with the physicians and surgeons holding the degree of Doctor of Medicine.

Applicants for licensure are first required to meet the standards and provisions of the Basic Science Act.

Editor's Note: At a conference in February, 1959, between representatives of the Florida Medical Association and the Florida Osteopathic Medical Association, officers of the Florida Medical Association agreed to have published in The Journal of the Florida Medical Association, as a source of information to its members, a factual account of the present status of osteopathy in the state and in the nation, to be prepared by the Florida Osteopathic Medical Association. The informative article here presented was submitted for publication in June 1959. The recent action by the House of Delegates of the American Medical Association, followed by the action of the House of Delegates of the American Osteopathic Association makes this presentation particularly timely.

Qualified doctors are then licensed to practice osteopathic medicine and surgery by the Board of Osteopathic Medical Examiners under statutory standards of professional education and training similar to those of the Medical Practice Act, including for graduates since 1948 a required one year hospital internship. Professional regulation and administration under the Osteopathic Practice Act are subject to the same general statutory provisions as are applicable to the Board of Medical Examiners and other professional licensing boards.

These doctors of osteopathy are located in 92 cities and towns of the state. Approximately 146 of the doctors were graduated from osteopathic colleges since 1945. They do not practice in public or private medical hospitals in the state, but confine their hospital care to 18 osteopathic hospitals located in 16 cities in the state furnishing, in all, 425 hospital beds and 88 bassinets. The largest osteopathic hospital has 48 beds and the smallest hospital has 10 beds.

These hospitals provide general medical and surgical care. All the osteopathic hospitals are private hospitals, most of them being nonprofit charitable corporations. None of the hospitals are operated by or for the state government. There are, for purposes of comparison, 161 medical hospitals in Florida, and of this number, 65 are of a size of 50 beds or less.[1]

Doctors of osteopathy tend largely to be engaged in general practice in the state. Twenty-two are certified in a specialty field of practice by one of the American Osteopathic Specialty Boards. The classifications are in anesthesiology (1), internal medicine (1), pediatrics (3), proctology (5), ophthalmology and otolaryngology (4), roentgenology (2), radiology (1), obstetrics and gynecology (1), and surgery (6).

Others are engaged in specialty training programs including residencies and required clinical specialty practice following a residency needed to qualify for certification under one of the American Osteopathic Boards of specialty practice. Two osteopathic hospitals in the state are approved for intern training by the American Osteopathic Association.

Doctors of osteopathy in Florida participate in rendering care under state public health plans, voluntary health insurance, private employer health plans and related health or welfare programs under the same general conditions or requirements applicable to doctors of medicine. Generally speaking, the Florida public health statutes place upon doctors of osteopathy the same responsibilities and duties under such laws as are applicable to doctors of medicine. This situation exists in part because most of such laws place such duties or responsibilities on "licensed physicians" and that term legally has been construed to include doctors of osteopathy and doctors of medicine.[2]

*Reprinted from the September, 1959, Issue of the Journal of the Florida Medical Association.

The Six Osteopathic Colleges

There are only six colleges of osteopathic medicine in the United States. They are:

1. Chicago College of Osteopathy, Chicago, Ill.
2. College of Osteopathic Physicians and Surgeons, Los Angeles, Calif.
3. College of Osteopathic Medicine and Surgery, Des Moines, Iowa.
4. Kansas City College of Osteopathy and Surgery, Kansas City, Mo.
5. Philadelphia College of Osteopathy, Philadelphia, Pa.
6. Kirksville College of Osteopathy and Surgery, Kirksville, Mo.

These colleges are the only colleges in the United States or elsewhere granting the degree of Doctor of Osteopathy. They are approved by the Bureau of Professional Education and Colleges of the American Osteopathic Association, and otherwise as described in a later paragraph. The osteopathic profession has no foreign medical school problem, and only 192 doctors of osteopathy practice outside of the United States or its territories.

The Educational Standards established by the Bureau of Professional Education and Colleges of the American Osteopathic Association are published annually in the January Educational Supplement to the Journal of the American Osteopathic Association.[3] This Educational Supplement contains detailed information and statistics concerning all phases of preprofessional and professional education.

In addition, Medical School Inquiry—Staff Report to the Committee on Interstate and Foreign Commerce, House of Representatives, Eighty-Fifth Congress, First Session, a study recognized as one of the most comprehensive ones made concerning medical education, on pages 115 to 145 contains further detailed information concerning osteopathic professional education, as well as on the educational programs of United States medical schools, foreign medical schools, and schools of dentistry and public health. The study is basic to efforts of the Federal Government to provide financial aid to the primary medical training resources of this country.

The Matriculation of Students

Applicants to osteopathic colleges today number approximately two applicants for each admission. The colleges conduct inquiries into the moral, personal, and social characteristics of the applicants. Osteopathic colleges utilize special tests to determine the qualifications of applicants, the best known of these tests being the Medical College Admissions Test administered by the Educational Testing Service of Princeton University, which approximately 85 per cent of those admitted to osteopathic colleges take.

Three osteopathic colleges use the University of Minnesota Multiphasic Personality Index as a part of their admissions test. Four osteopathic colleges have a psychiatrist on their admissions committee. The osteopathic colleges rely heavily upon the recommendations of the premedical committees of the preprofessional colleges, and upon interviews conducted by members of the osteopathic profession in the locality where the applicant resides.

Required Preprofessional College Education

At the present time all six osteopathic colleges, and all but one medical school approved by the American Medical Association in the United States require of all applicants a minimum of three years preprofessional college education prior to matriculation. Harvard Medical School requires only two years of preprofessional college training, and the Johns Hopkins University School of Medicine will require only two years of preprofessional college study after Sept. 1, 1959. Contrary to preconceived notions, both medical and osteopathic colleges, while requiring a fairly large list of required subjects, accept students with averages as low as C or C plus for admission.

> The policies of over 50 per cent of medical schools call for no more than C or C+ averages, and 30 per cent of schools indicate minimal grade-average policy.[4]

Thirteen per cent of the matriculants in osteopathic colleges drop out because of academic failure, financial difficulties, or other reasons, and about 5 per cent in medical schools for the same reasons. In March 1959, 1,942 students were in training in the six schools of osteopathy. Approximately 467 students graduated in June 1959. In the fall of 1958, 66 per cent of the entering students in osteopathic colleges had received a bachelor's degree from their preprofessional college.

Both medical and osteopathic colleges in the United States, while meeting the minimum standards of preprofessional education established by their national professional associations, retain considerable local authority in accepting students. Both professions require the same basic preprofessional subjects, such as chemistry, English, mathematics, zoology and related subjects.

Professional Osteopathic Education

The osteopathic colleges include in their curriculums the same basic science subjects in the freshman and sophomore years and clinical subjects in the third and fourth years as presented in approved medical colleges. The Committee for the Study of Relations Between Osteopathy and Medicine of the American Medical Association in 1955 made the following conclusions concerning osteopathic education as a part of its lengthy study report:

> Current curriculums in colleges of osteopathy include all subjects taught in present-day schools of medicine. In addition, there are courses dealing with the musculoskeletal system and manipulative therapy. The degree of emphasis upon these courses is variable and is diminishing. At none of the colleges was there evidence that these courses interfered with the achievement of sound medical education.[5]

The colleges utilize hospital outpatient and clinic instruction for students in their junior and senior years. The six usual basic science departments of anatomy, pathology, bacteriology, physiologic chemistry or biochemistry, physiology, and pharmacology are found in the osteopathic colleges. The clinical instruction in the junior and senior years in osteopathic

colleges falls into similar compartments, such as the Departments of Medicine or Osteopathic Medicine, Surgery, Obstetrics, Pediatrics, Neurology, Psychiatry, and other clinical areas.

The instructors and professors in the basic science subjects are generally full time men on the faculties, while in the clinical years the faculty members are doctors of osteopathy, who may or may not be full time men, and if not, the instruction will be partially given by part time doctors engaged in private practice in the localities of the schools. Some clinical departments may have a fairly large percentage of full time men and others few, relying more on part time men.

The objective of osteopathic colleges is to train a well rounded general practitioner, capable of advancing into specialized practice upon the completion of further postgraduate training. All of the osteopathic colleges have some postgraduate teaching responsibilities, but they are limited largely to interns and residents, and some United States Public Health Service fellowships in both undergraduate and graduate medicine. Regular short postgraduate courses for practicing physicians are also conducted by the colleges.

Some doctors of medicine teach in osteopathic colleges, but no doctors of osteopathy teach in medical schools. Four doctors of medicine, for example, are on the faculty of the Chicago College of Osteopathy.

Use of Drugs, Surgery Taught

All of the osteopathic colleges are located in states where all of the doctors of osteopathy may qualify for an unlimited license to use drugs and perform operative surgery. All osteopathic schools have a department of pharmacology similar to that in medical schools, and it is this department which is responsible for instruction in the area most closely related to instruction in the use of drugs. The subject of materia medica is now an obsolete course in both medical and osteopathic colleges.

The clinical use of drugs and surgery are taught during the third and fourth year externships which the students serve in the teaching hospitals and outpatient clinics. During this period, students prescribe and administer drugs and assist in surgery under the direction and supervision of the clinical instructors. Development of the teaching in surgery follows the usual pattern, commencing with anatomy in the basic sciences and being followed up in the clinical years with observation and assisting in surgical operations.

The case records of osteopathic hospitals are maintained in accordance with standard medical procedure and cover the usual hospital entries or records maintained in medical hospitals. With the exception of the Detroit Osteopathic Hospital, Detroit, Mich., a 425 bed teaching hospital of the Chicago College of Osteopathy, and the Osteopathic Unit of the Los Angeles County General Hospital, the 500 bed teaching unit of the College of Osteopathic Physicians and Surgeons, the teaching hospitals of the osteopathic colleges do not run as large in size as those affiliated with medical schools. Most of the osteopathic teaching hospitals fall into the 100-bed to 225-bed capacity as compared with medical teaching hospitals, which are usually in the 300-bed to 500-bed category or larger.

College Approval and Accreditation

The American Osteopathic Association (AOA), through its Bureau of Professional Education and Colleges, is a constituent member of the American Council on Education. The American Association of Osteopathic Colleges (AAOC) also is a constituent, or voting, member of the American Council on Education. It is represented on the Bureau of Professional Education and Colleges of the American Osteopathic Association.

Every four years the American Council on Education publishes "American Universities and Colleges," which includes all undergraduate institutions and all approved professional colleges in the United States. The last edition of "American Universities and Colleges" was published in 1956.

Part II of this book is entitled "Professional Education in the United States." Pages 162 and 163 include a section on osteopathy dealing with the history of osteopathic education, furnishing educational statistics about osteopathic education and listing the approved colleges of osteopathy. This section specifically states that the American Osteopathic Association, through its Bureau of Professional Education and Colleges, is recognized "by the various state licensing authorities and departments of the Federal Government as the accrediting agency of osteopathic colleges." Approval of the osteopathic colleges includes their general hospitals, which are a part of all osteopathic colleges.

Six Accrediting Associations

Apparently, there still exist some misunderstandings in various areas over the official accrediting procedures for undergraduate education in the United States. There are six accrediting associations responsible for the accreditation of institutions with liberal arts and general programs, and, in some cases, those with special programs in undergraduate education, such as engineering. These associations are as follows:

The New England Association of Colleges and Secondary Schools

The Middle States Association of Colleges and Seconary Schools

The North Central Association of Colleges and Secondary Schools

The Northwest Association of Secondary and Higher Schools

The Southern Association of Colleges and Secondary Schools

The Western College Association

Undergraduate institutions in a state come under the jurisdiction of the appropriate regional accrediting agency. The University of Miami, for example, is approved by the Southern Association of Colleges and Secondary Schools. The University of Miami School of Medicine, on the other hand, or any other United States medical college, is approved only by the Council

on Medical Education and Hospitals of the American Medical Association.

In other states, the same can be said, namely, that nonprofessional education comes under the regional accrediting agency, and the professional education under the appropriate professional accrediting agency, which for the medical education institutions is the American Medical Association and for osteopathic colleges is the American Osteopathic Association.[6]

Osteopathic college education credits are accepted by leading universities including Michigan State University, Syracuse University, University of Omaha, and others under a combined degree program permitting osteopathic students to receive their bachelor's degree while in their first or second year in osteopathic colleges. This combined degree program is fully explained in the Educational Supplement to the Journal of the American Osteopathic Association.

Hospital Internships

A hospital internship is a condition for licensure of osteopathic doctors graduating since 1948 under the present Osteopathic Practice Act, but not under the Medical Practice Act of Florida. Twenty-nine states, including Hawaii, and the District of Columbia today require, by law or regulation, an internship as a condition for the unlimited licensure of doctors of medicine and 24 states, including Hawaii, and the District of Columbia require a hospital internship for doctors of osteopathy.

Hospitals providing intern training must, in the states having such a requirement, be approved by the professional licensing boards. In the medical profession such hospitals are voluntarily approved by the Council on Education and Hospitals of the American Medical Association and for the osteopathic profession by the Bureau of Hospitals of the American Osteopathic Association. No medical or osteopathic college requires an internship as a prerequisite to the Doctor of Medicine or Doctor of Osteopathy degree.

An internship in the osteopathic profession is a 12-month hospital training program covering the fields of medicine, surgery, obstetrics, and related fields such as pediatrics, radiology and anesthesiology, and meeting the standards for intern training established and administered by the Bureau of Hospitals of the American Osteopathic Association. All but seven of the 439 graduates of osteopathic colleges in 1958 are now engaged in completing their one-year hospital internship.

Specialty Boards and Residencies

Boards or colleges of specialty practice or certification are maintained under the direction of the American Osteopathic Association. The standards of the specialty boards are published in the March issue of the Journal of the American Osteopathic Association.[7] A recent study[8] indicated that 845 doctors of osteopathy in the United States limit their practice to one of the recognized specialty fields such as surgery, obstetrics, psychiatry, or pediatrics, there being 12 American Osteopathic Boards of specialty certification in all. The same study indicated that 1,333 of the 13,400 doctors of osteopathy in the United States limit their practice to manipulative practice. The great percentage are in general practice.

The licensing of doctors of osteopathy itself does not involve residency training; other than that in some states, doctors serving hospital residencies in such specialties as surgery, obstetrics, pediatrics, psychiatry and related fields may be exempt from licensure during the hospital residency period, which is generally three years in length. No state requires a residency as a condition to licensure.

Residencies are a condition to certification by the 12 voluntary specialties boards of the American Osteopathic Association. In surgery, for example, the American Osteopathic Board of Surgery requires a person seeking certification in surgery to have assisted during his formal training in not less than 400 major surgical operations and to have performed a minimum of 200 major surgical operations on his own responsibility upon completion of his three years of formal training.

Research

Research is recognized as a desirable part of the functions of an osteopathic college and the education of an osteopathic physician and surgeon. The osteopathic colleges do not have, however, the finances or personnel to provide training in research to anywhere near the extent available in medical schools. The United States Public Health Service provides some research grants, fellowships, and also postdoctoral fellowships to the osteopathic colleges and osteopathic graduates.

Research in the osteopathic colleges is directed at basic studies of fundamental phenomena of the musculoskeletal system, and not at areas relating to current therapy. Reports on the research programs of the osteopathic profession are periodically reported in the Journal of the American Osteopathic Association and in other scientific journals.

Licensing in Other States

The doctors of osteopathy are licensed fully to practice medicine and surgery, or under a license including the use of drugs and surgery, in 37 states, including Hawaii, and in the District of Columbia. The licensing boards in these unlimited license states are in 16 states composed of doctors of osteopathy only; in 17 states of both doctors of medicine and doctors of osteopathy; in three states of doctors of medicine only; and in two states there are two boards, one composed of doctors of osteopathy only and the other composed solely of doctors of medicine, but only the medical board may issue an unlimited license.

The legal standards of the medical and osteopathic boards are comparable; 25 of the boards in all, as noted, require an internship as a condition to licensure. All require that the doctor of osteopathy be a graduate of one of the six osteopathic colleges approved by the American Osteopathic Association. Ninety-two per cent of the doctors of osteopathy prac-

tice in the unlimited states, and a large percentage of the other doctors of osteopathy hold unlimited licenses in states other than the states in which they are located. In the years between 1952 and 1956 alone, Boards of Medical Examiners issued 1,296 licenses to practice medicine and surgery to doctors of osteopathy.

The medical examining boards which license doctors of osteopathy to practice medicine and surgery in all instances have a majority of their members with the Doctor of Medicine degree. In a state like Texas, for example, three doctors of osteopathy are members of the Texas Board of Medical Examiners and doctors of osteopathy have been licensed to practice medicine and surgery since 1907. In Colorado, they have been licensed to practice medicine and surgery since 1917, and in other states for similar long periods of time. In another state, Kansas, a new Kansas Healing Arts Board with five doctors of medicine and three doctors of osteopathy was established in 1957, and a doctor of osteopathy is, this year, serving as the President of the Board.

One or more doctors of osteopathy serve, in addition, on the Boards of Medical Examiners in the states of Colorado, Delaware, Indiana, Kentucky, Massachusetts, New Jersey, New York, Ohio, Oregon, South Dakota, Virginia, Wisconsin, and Wyoming, and in the District of Columbia.

The unlimited licenses issued to the doctors of osteopathy vary in name and may be called a physician's and surgeon's certificate, or a license to practice medicine and surgery, medicine, osteopathic medicine and surgery, or osteopathy, or a similar name.

Status Under Federal Laws

Doctors of osteopathy and doctors of medicine have almost an identical status under federal laws. The most important exception is that while doctors of osteopathy are eligible to be appointed to the Medical Corps of the Army, Navy, and Air Force as Commissioned Medical Officers, no such appointments have yet been made. Doctors of osteopathy are now serving as Medical Officers of the United States Public Health Service and Veterans Administration. A fairly large number are Reserve Medical Officers of the United States Public Health Service and serve on active duty for two weeks of each year. Osteopathic doctors provide medical services or prepare medical certificates under all of the various federal laws requiring such services or certificates.[9]

Osteopathic colleges receive educational grants from the United States Public Health Service to assist the training of student doctors in mental health, cancer, and cardiovascular diseases. Numerous osteopathic hospitals have received large federal grants-in-aid to assist in their construction under the Hill-Burton Act.

A United States Public Health Service report recently published compared the knowledge of students in osteopathic and medical colleges receiving cancer teaching grants.[10] The results showed the osteopathic students had a slightly greater cancer treatment knowledge in the freshman and sophomore years and the medical students in the junior and senior years. The differences, however, were not great in any one year. A federal bill supported by the United States Department of Health, Education, and Welfare and by President Eisenhower favors financial grants for the expansion of medical and osteopathic schools.

Federal regulations in some of the health plans require that a participating doctor possess an unlimited license, as for example the Medicare Program for dependents of Armed Forces personnel. In such instances, the few doctors of osteopathy in the limited states may not participate because of limited licensure. The basic law enacted by the United States Congress in 1929 regulating the practice of medicine and osteopathy in the District of Columbia provides:

> The degrees doctor of medicine and doctor of osteopathy shall be accorded the same rights and privileges under governmental regulations.

Accreditation of Hospitals

There are approximately 400 osteopathic hospitals in the United States providing general hospital care, including those earlier referred to located in Florida. These hospitals are located in 22 states. They provide an estimated 12,000 hospital beds. In some areas, particularly in the less heavily populated urban areas. they may furnish the only available hospital facilities or an important part of such facilities. The American Osteopathic Hospital Association is the official national membership organization of the hospitals, but the registration or approval program for such hospitals is maintained by the American Osteopathic Association.

There are categories of accreditation of hospitals in both the medical and osteopathic professions. The various states license medical and osteopathic hospitals under state hospital licensing laws, and in addition, the professional licensing boards approve hospitals for intern training. The American Osteopathic Association conducts a voluntary hospital accreditation program through its Bureau of Hospitals and "registers" hospitals for general medical and surgical care; it also "approves" hospitals for intern and residency training in accordance with prescribed standards.

The American Medical Association "approves" medical hospitals for intern training. The American Hospital Association "lists" medical hospitals for general medical and surgical care, and the Joint Commission on Accreditation "accredits" medical hospitals with 25 or more beds. The medical and hospital organizations do not permit doctors of osteopathy on the staffs of hospitals which they approve, list, or accredit. The American Osteopathic Association, on the other hand, does not prohibit doctors of medicine from serving on the staffs of osteopathic hospitals, or public hospitals jointly staffed by doctors of osteopathy and doctors of medicine, which are approved or registered by it.

The Approach

The approach of the osteopathic school of medicine has been greatly influenced by advances in scientific medicine. The colleges from the earliest days included

instruction in drugs and surgery, although this fact was for a long period of time questioned. In a Missouri decision[11] in 1952, the St. Louis Court of Appeals set forth the corporate charter of the original school established in 1892, the Kirksville College of Osteopathy and Surgery:

> The object of this Corporation is to establish a College of Osteopathy, the design of which is to improve our present system of Surgery, Obstetrics and treatment of diseases generally and place the same on a more rational and scientific basis to impart information to the medical profession and to grant and confer such honors and degrees as are usually granted and conferred by reputable Medical Colleges, to issue diplomas in testimony of the same to all students graduating from said School under the seal of the Corporation with the signature of each member of the faculty and of the President of the College.

Trial court Findings of Fact and Conclusions of Law in this case held that the College had, from its beginning, included all areas of diagnosis and therapy, including drugs and surgery, as a part of its curriculum and course of training.[12]

The intervening years until the present day were ones which saw differences of opinion between the medical and osteopathic professions. The Journal of the American Osteopathic Association, in particular, in recent issues has sought to reconcile these differences and places much of the burden for the differences on semantics. In simplest language, the approach of the osteopathic profession has been that it recognizes the importance of the musculoskeletal system, along with the other body systems, in the diagnosis and treatment of human ailments and diseases. It is not contended that all disease is caused by derangements of the musculoskeletal system, but that evaluations of such factors should be considered in treating the patient as a whole person.

Manipulation

Manipulation, along with other therapies of physical medicine, is adaptable to the treatment of derangements of the musculoskeletal system. The osteopathic doctor utilizes manipulative procedures where needed in practice. As noted earlier, the number of doctors of osteopathy restricting their practice to a manipulative practice approximates 10 per cent.

It is well to remember that manipulation itself is an old therapy, going back for its origin to the days of Hippocrates. Osteopathy as a school of medicine helped to bring new attention to this therapy. Current medical publications discuss its use frequently. James B. Mennell, M.D., author of "The Science and Art of Joint Manipulation," in his text states:

> An enormous amount of human disability and suffering is amenable to treatment by manipulation, even to the extent of cure. There are other conditions in which manipulative treatment can be of service in reducing disability to the minimum, when without it the patient would suffer unnecessary disability or discomforts. There is no doubt that the final downward fall into complete incapacity can often be postponed in cases of incurable disease by manipulation. I can, however, only say that my experience so far has failed to convince me that any ordinary pathological process within the body is altered materially for the better or the worse with three exceptions: First, there are many complaints which owe their origin entirely to disturbance of joint function and recovery is impossible unless the joint function is restored to normal by manipulation; second, that the symptoms which can arise as a result of a joint derangement will often simulate organic disease and that these cases remain incurable unless the joints are examined and the necessary adjustment made; third, that if pathological changes within the body are present, a great deal may be done for the benefit of the patient by joint manipulation, even though it has no direct effect upon the main pathological condition present.

The osteopathic position is that osteopathy's training and education fall within the scope and character of modern scientific medicine. The 1955 American Medical Association report itself stated that the courses in the colleges dealing with the musculoskeletal system and manipulative therapy did not interfere with "the achievement of sound medical education." The unlimited practice of medicine and surgery in some states for as long as 60 years, and in Florida for over 30 years, in the care and treatment of disease supports this position. There does not appear to be any greater problem involved in the integration of manipulation with drugs and surgery in the osteopathic profession than there is in the use of physical medicine by the medical profession.

The AMA and AOA

For a long period of time, the American Medical Association, under its Code of Ethics, has declared that the practice of osteopathy constitutes "cultist" healing and that, therefore, voluntary associations between doctors of medicine and doctors of osteopathy are unethical. This ruling does not prohibit "involuntary associations" between them.[13] Where by public law, regulation, or health needs of patients doctors of osteopathy and doctors of medicine are required to or must associate together, the American Medical Association does not in any way prohibit such joint activity because it is involuntary.

Thus, doctors of osteopathy attend postgraduate education at such medical schools as the University of Colorado School of Medicine, University of California School of Medicine and University of Washington School of Medicine, and staff jointly a minimum of some 75 public hospitals operated by counties or cities throughout the country. In addition, certain private hospitals are jointly staffed by doctors of medicine and doctors of osteopathy; for example, Rio Hondo Hospital in Downey, Calif., is approved for the training of interns by the American Osteopathic Association.

The Question of Ethics

The Code of Ethics of the American Medical Association is construed differently throughout the country by the various state medical societies and medical organizations. The Kansas Medical Society, for example, holds that voluntary relationships between doctors of medicine and doctors of osteopathy are ethical and that there is no ethical prohibition preventing joint activities of doctors of medicine and doctors of osteopathy based apparently upon the health needs of the people. The Mayo Clinic of Rochester, Minn., will accept referrals of patients and send reports back to doctors of osteopathy, but some other medical institutions will not.

Doctors of osteopathy in New England and interns at the Massachusetts Osteopathic Hospital attend postgraduate courses given by the Post-Graduate Medical Institute, Boston, Mass., a school carried on by leading medical organizations and schools in Massachusetts.

Doctors Hospital, an osteopathic hospital in Columbus, Ohio, has a part of its basic science instruction in its residency programs presented by instructors of the Ohio State University College of Medicine, a medical school approved by the American Medical Association.

In the years between 1952 and 1955, the Committee for the Study of Relations Between Osteopathy and Medicine of the American Medical Association and the Conference Committee of the American Osteopathic Association met and discussed the matter of the relationships between the professions. The first report of these conferences was published in the June 20, 1953, issue of the Journal of the American Medical Association and the second report in the July 2, 1955 issue of that Journal.

The position of the American Medical Association itself was stated to be:

> The American Medical Association is dedicated to the purpose of improving the health and medical welfare of the American people. The osteopathic profession supplies medical care to millions of Americans. In many areas, the only immediately available medical care is by osteopaths. . . . The past of Osteopathy is unimportant. Its present, and particularly its future, are important to the medical care of the American people.

The American Medical Association reports previously referred to were prepared by a committee which included in its membership, at one time or another, members of the Board of Trustees of the American Medical Association, the present Executive Vice President of the American Medical Association, the immediate past chairman of the Board of Trustees of the American Medical Association, the present chairman of the Board of Trustees of the American Medical Association, a past president of the American Medical Association, and other medical educators and leaders of the profession.

At the June 1955 meeting of the House of Delegates of the American Medical Association, the recommendations of its Committee for the Study of Relations Between Osteopathy and Medicine failed to receive the approval of the House of Delegates by a vote of 101 to 80. At the June 1958 meeting of the House of Delegates, a resolution requesting that the matter of the relationship between doctors of medicine and doctors of osteopathy be further studied by the House of Delegates was introduced by a delegate representing the Missouri State Medical Association. This resolution made reference to the previous study of the Committee for the Study of Relations Between Osteopathy and Medicine and requested that the matter of relationships between doctors of medicine and doctors of osteopathy be given further consideration. The resolution was not acted upon by the House of Delegates. In Minneapolis in December 1958 at the Clinical Meeting of the American Medical Association, the following action was taken:

> Osteopathy: No. 10.—Dr. Wendell C. Stover, Indiana, introduced a resolution which requested the House of Delegates of the American Medical Association to recognize that the constituent medical associations have the right to establish the relationship of the medical profession to the osteopathic profession within their respective states.
> The Reference Committee on Medical Education and Hospitals discussed the resolution at great length; it noted with favor that the American Osteopathic Association has amended its objectives as stated in its Constitution by deleting reference to the cultism of Andrew J. Still. However, the committee did not believe the resolution offered the appropriate solution to this problem and therefore recommended that (1) the resolution not be approved, (2) that the Judicial Council be requested to review the past pronouncements of the House of Delegates with respect to osteopathy and the status of the laws of the various states in this regard, and (3) that the Judicial Council, if possible, present its report and recommendations at the next meeting of the House.[14]

The special report on the subjct of osteopathy, made by the Judicial Council to the House of Delegates at the 108th Annual Meeting of the American Medical Association in June 1959, led to the adoption by the House of the following policy statement regarding interprofessional relations:

> (A) All voluntary professional associations between doctors of medicine and those who practice a system of healing not based on scientific principles are unethical.
> (B) Enactment of medical practice acts requiring all who practice as physicians and surgeons to meet the same qualifications, take the same examinations and graduate from schools approved by the same agency should be encouraged by the constituent associations.
> (C) It shall not be considered contrary to the Principles of Medical Ethics for doctors of medicine to teach students in an osteopathic college which is in the process of being converted into an approved medical school under the supervision of the A.M.A. Council on Medical Education and Hospitals.
> (D) A liaison committee be appointed by the Board of Trustees of the American Medical Association to meet with representatives of the American Osteopathic Association, if mutually agreeable, to consider problems of common concern including interprofessional relationships on a national level.

In another action relating to osteopathy at that meeting, the House of Delegates of the American Medical Association recommended that its representatives on the Joint Commission on Accreditation of Hospitals suggest to the Joint Commission that they inspect upon request and consider for accreditation without prejudice those hospitals required by law to admit osteopathic physicians to their staff.

The matter rests here at the present time. There is little doubt that the American Medical Association's study reports of 1952 and 1955 have resulted in better relationships between doctors of medicine and doctors of osteopathy throughout the country. The two reports have received wide attention and discussion, not only in medical and osteopathic circles, but also in governmental circles.

Most of the present problems involving doctors of medicine and doctors of osteopathy would be eliminated by the dropping of the "cultist" designation by the American Medical Association in its application to doctors of osteopathy. The June 1959 policy statement of the American Medical Association regarding interprofessional relations marks another forward step in improving the relationship between the two professions, but the policy statement as it now stands "is too high a price to pay," so stated the President of the American Osteopathic Association at the July meeting of the House of Delegates. The following resolution adopted by the House at the same meeting represents the official position relative to the present policy of the American Medical Association.

> That the osteopathic school of medicine in the interest of providing the best possible health care to the public shall maintain its status as a separate and a complete school of medicine, cooperating with all other agencies and groups that sincerely promote the same objective, when that cooperation is on an equal basis granting full recognition to the autonomy and contribution of the osteopathic school of medicine.

Conclusion

The osteopathic profession in Florida is a part of a national profession of doctors who, by law, and

(Continued to Page 318)



Indigent Medical Care

IF one follows with interest the activities of the Kentucky State Medical Association, he will almost invariably develop a very sincere admiration and sense of appreciation for those men who from year to year devote a great deal of time and thought and energy to the development of programs designed to improve the health of our people.

The most recent major problem presented to our Association is the means of implementing the Indigent Medical Care Program. These plans were developed jointly by the Governor's Advisory Council and physicians working on the committee appointed by the KSMA. Our committee, for several years, has been under the chairmanship of Dr. Gaithel Simpson, our president-elect. It would be impossible to tabulate the amount of work Dr. Simpson and his committee have devoted to this concern.

In the winter of 1960 our Legislature authorized a program of indigent medical care for public-assistance recipients which included the aged, permanently and totally disabled, the blind who were without means of adequate support and dependent children. With the passage of the Kerr-Mills Bill in the summer of 1960 a second group, the indigent aged, became eligible to receive medical care under the same program. It is estimated that the combined groups constitute about 180,000 citizens of Kentucky who are now to be covered in the best measure possible with the funds available from the state and federal sources.

Kentucky has never had an indigent medical care program under state supervision and becomes the forty-fifth state to inaugurate such a plan. It is said, and with considerable reason, that the amount of money available for the implementation of such a plan to cover so large a group of recipients is discouraging and that the medical aid rendered to those who most need it will necessarily be on a minimum basis. That should be no matter of great discouragement to us. We look with some envy upon our neighboring states who, with a third the number of recipients, have available nearly twenty times our amount of money, but we must remember that such programs have long since been developed in these states and have grown gradually over a great many years. In all probability the beginning of the operation was as inauspicious as is ours.

The Board of Trustees of the Kentucky State Medical Association met in January to consider in detail the various problems incident to the implementation of this program. Considerable adverse and constructive criticism was expressed at this meeting, but during a day of tedious but very constructive work the Board came forth with firm recommendations to the Kentucky State Medical Association that it participate as an association and as individual members in bringing to our medically indigent the very best care possible under the plan authorized. Since that time, the board of governors of Jefferson County Medical Society has officially endorsed the position taken by the board of trustees of the KSMA and the governing boards of a number of other county societies have done likewise.

One item under prolonged discussion was the manner in which a fee schedule for service rendered these recipients could be planned. It seemed best to recommend that the physician rendering service indicate on the form the usual fee that he would charge for this service, under average circumstances, with the agreement that payment would be made in proportion to the

amount of money available at the end of each month which had been assigned specifically for physicians' remuneration. There was very little disagreement to this plan which was thought by those present to be the most nearly fair and ethical of all plans suggested.

Objection was raised to the forms that must be completed in the operation of this program. Physicians are opposed to the necessity for the completion of tedious forms, particularly when the remuneration for such work is minimal. It is felt by the Board of Trustees that patience and cooperation should be exercised in this matter. Valuable data such as the extent of medical care rendered and the per cent of payment received therefor will be helpful in projecting the program into the future. It was felt further that the present long and tedious forms would, as rapidly as possible, be improved. When one is familiar with the execution of such forms, it can be done with a minimum of his own attention and the detail delegated principally to his office secretary, thereby relieving him of unnecessary expenditure of time and effort.

The Kerr-Mills Bill has been embraced by the medical profession generally as a better program than that offered by Forand type of legislation, now under consideration by the Congress and which proposes to put the entire operation of old aged medical care under social security. We have been challenged to sponsor and support a program which it deems better and more economical than that proposed by the present administration. It seems logical and essential that we make every effort to render its operation effective.

Sam A. Overstreet, M.D.

A Study In Distortion

ON THURSDAY evening, February 2, CBS presented on its TV show, "CBS Reports," a program entitled, "The Business of Health, Medicine, Money and Politics."

Members of the medical profession, as well as many lay people, were profoundly shocked and stunned at this "caricature of medicine and its aims."

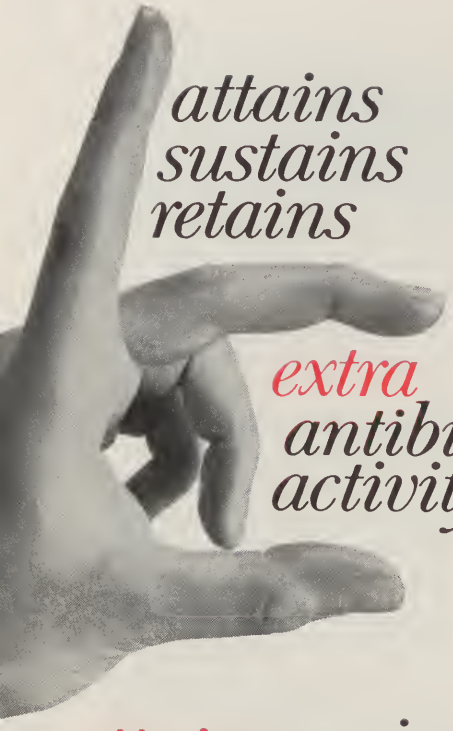
The Board of Trustees of the AMA responded by accusing the Columbia Broadcasting System of "misrepresentation, bias and distortion." The trustees stated, "We are amazed that a major national television network, with its grave responsibility to safeguard the truth in examining the great issues of the day, would permit such a distorted program to be presented in the guise of objective reporting.

"We believe that CBS has performed a historic disservice to the people of this country. The producer of the program selected the most unrepresentative quotes from the AMA, twisted them out of context and positioned them in a manner most favorable to the friends of governmental medicine."

Each of us must do all he can to correct the poor image of the AMA and of the medical profession that the American public is getting. The true image is that most doctors are dedicated men who are concerned with the health, happiness and security of their patients and are interested in those things that lead to higher standards of medical care. It is our belief that high standards of medical care can be maintained only if red tape, rigid regulations, restrictions, regimentation and politics are kept out of medicine.

As American citizens we are intensely interested in the future of our great country. Is it wrong, therefore, for us to oppose measures that gradually take away our American freedoms? I do not think it is. I believe we must stand firm for those things in which we believe and know to be right and communicate these beliefs to others.

George W. Pedigo, Jr., M.D.



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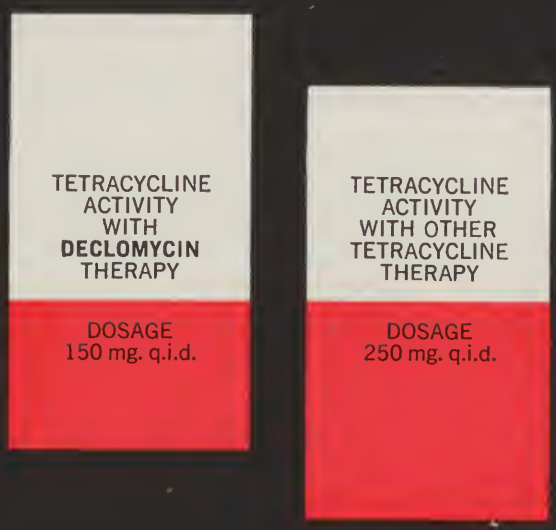
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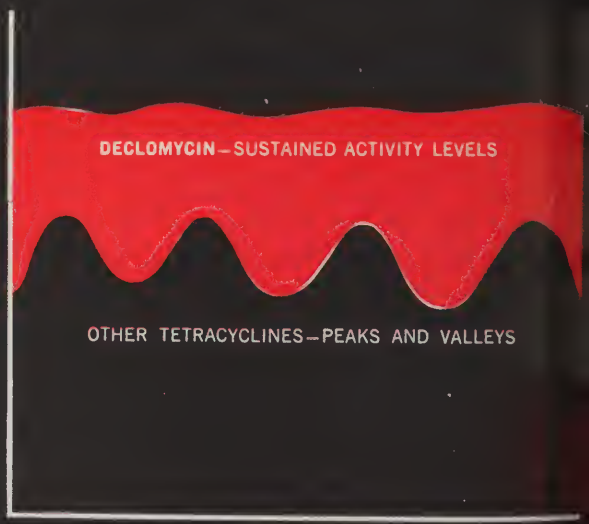
DECLOMYCIN Demethylchlortetracycline attains—usually within two hours—blood levels more than adequate to suppress susceptible pathogens—on daily dosages substantially lower than those required to elicit antibiotic activity of comparable intensity with other tetracyclines. The average, effective, adult daily dose of other tetracyclines is 1 Gm. With DECLOMYCIN, it is only 600 mg.

sustains activity levels evenly

DECLOMYCIN Demethylchlortetracycline sustains through the entire therapeutic course, the high activity levels needed to control the primary infection and to check secondary infection at the original—or another—site. This combined action is usually sustained without the pronounced hour-to-hour, dose-to-dose, peak-and-valley fluctuations which characterize other tetracyclines.



POSITIVE ANTIBACTERIAL ACTION



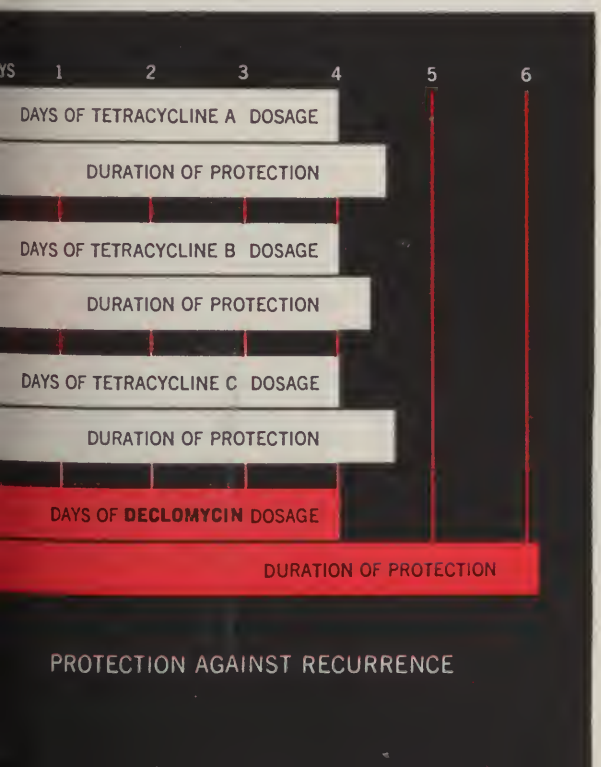
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DEMETHYLCHLORTETRACYCLINE LEDERLE

etains activity evels 24-48 hrs.

ECLOMYCIN Demethylchlortetracycline retains activity levels up to 48 hours after the last dose is ven. At least a full, extra day of positive action may us be confidently expected. The average, daily adult osage for the average infection—1 capsule q.i.d.—the same as with other tetracyclines...but **total** osage is lower and duration of action is longer.



CAPSULES, 150 mg., bottles of 16 and 100. **Dosage:** Average infections—1 capsule four times daily. Severe infections—Initial dose of 2 capsules, then 1 capsule every six hours.

PEDIATRIC DROPS, 60 mg./cc. in 10 cc. bottle with calibrated, plastic dropper. **Dosage:** 1 to 2 drops (3 to 6 mg.) per pound body weight per day—divided into 4 doses.

SYRUP, 75 mg./5 cc. teaspoonful (cherry-flavored), bottles of 2 and 16 fl. oz. **Dosage:** 3 to 6 mg. per pound body weight per day—divided into 4 doses.

PRECAUTIONS—As with other antibiotics, DECLOMYCIN may occasionally give rise to glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis or dermatitis. A photodynamic reaction to sunlight has been observed in a few patients on DECLOMYCIN. Although reversible by discontinuing therapy, patients should avoid exposure to intense sunlight. If adverse reaction or idiosyncrasy occurs, discontinue medication.

Overgrowth of nonsusceptible organisms is a possibility with DECLOMYCIN, as with other antibiotics. The patient should be kept under constant observation.

Lederle

LEDERLE LABORATORIES
A Division of
AMERICAN CYANAMID COMPANY
Pearl River, New York

ORGANIZATION SECTION

'Best Yet' Is Prediction For County Society Officers Conference

In Lexington April 6 As Six Authorities Get Billing As Speakers

With six experts in the fields of legislation and medical economics headlining the program, the 11th Annual County Society Officers Conference in Lexington April 6 promises to be the "best yet," according to KSMA President Richard G. Elliott, M.D., Lexington.

Doctor Elliott especially urges the attendance of county officers and committee chairmen, while inviting all KSMA members to attend.

The conference is returning to eastern Kentucky after moving to Owensboro for the 1960 meeting.

The roster of distinguished speakers includes Congressman John C. Watts, from Kentucky's Sixth District; three AMA leaders, and representatives from the National Blue Shield Commission and the American Farm Bureau Federation. At the morning session, they will take up problems of concern within the profession. The afternoon will be devoted to discussion of medicine's present position in the legislative arena. The complete program appears on the opposite page.

Introducing the Speakers

The following thumbnail sketches will serve as preliminary introductions to the speakers:

LEO E. BROWN, Chicago—As director of communications for the AMA. Mr. Brown supervises the Association's public and professional relations program, *Today's Health, The AMA News,* as well as the organization's exhibit and medical motion picture and television activities. He joined the AMA staff in December, 1950, as the first executive secretary of the Student AMA and moved up to his present post the following March. He is a former director of health education of the Erie County Health and Tuberculosis Association, Erie, Pa., and former executive assistant of the Medical Society of the State of Pennsylvania.



Mr. Brown

ROGER FLEMING, Washington, D. C. — The secretary-treasurer and director of the American Farm Bureau Federation's Washington office, Mr. Fleming has a background of more than 20 years in Farm Bureau administration. After receiving a degree in agricultural economics from Iowa State College in 1938, he became head of the newly-created Research Department of the Iowa Farm Bureau, whose state legislative activities he directed from 1939 to 1943. He served two and a half years as a commissioned officer in the U. S. Navy during World War II. On May 15, 1948, he was made head of the Washington office of the American Farm Bureau Federation and in December, 1949, took over the duties of secretary-treasurer.



Mr. Fleming

RAYMOND M. McKEOWN, M.D., Coos Bay, Ore.—A practicing physician at Coos Bay, Doctor

(Continued on Page 272)

Awards, Nominating Committees Of KSMA to Meet April 6

The KSMA Awards Committee and Nominating Committee will hold meetings during the luncheon session of the County Society Officers Conference at the Phoenix Hotel in Lexington on Thursday, April 6.

The Nominating Committee will nominate general officers of the Association for the 1961-62 associational year, to be voted on at the Annual Meeting, September 19-21. The Awards Committee is charged with submitting nominees for the KSMA Distinguished Service Medal and the Outstanding General Practitioner Award. The House of Delegates will vote on the nominees at its first meeting Monday evening, September 18.

KSMA members are encouraged to visit the specially marked tables at which these committees will sit during the luncheon session and make their recommendations.

Program

Eleventh Annual County Society Officers Conference

Phoenix Hotel, Lexington — **Thursday, April 6, 1961**

MORNING SESSION

Richard G. Elliott, M.D., Lexington, President
Kentucky State Medical Association, Presiding

9:00 a.m. **Registration**

9:25 a.m. **Coffee Call**

9:55 a.m. **Call to Order,** Doctor Elliott
Invocation, the Rev. Franklin Owen, Calvary Baptist Church, Lexington
Welcome, Joseph H. Saunders, M.D., Lexington, president, Fayette County Medical Society
Announcements, Woodford B. Troutman, M.D., Louisville, KSMA Secretary

10:00 a.m. **"Medicine, Blue Shield and Politics"**
Norman A. Welch, M.D., Boston, Mass., past chairman of the National Blue Shield Commission and president of the Massachusetts Medical Service

10:40 a.m. **"Medicine's Answer to Professional Disciplinary Problems"**
Raymond M. McKeown, M.D., Coos Bay, Ore., chairman, AMA Committee on Medical Discipline; member, AMA Board of Trustees

11:10 a.m. **Coffee Break**

11:20 a.m. **"The Town Crier"**
Mr. Leo Brown, Chicago, director, AMA Division of Communications

11:45 a.m. **Discussion**

LUNCHEON SESSION

Doctor Elliott, Presiding

12:25 p.m. **Invocation,** the Rev. Steadman Bagby, First Methodist Church, Lexington

1:00 p.m. **"A Congressman and His Constituents"**
The Honorable John C. Watts, Nicholasville, Congressman, Kentucky's Sixth District

AFTERNOON SESSION

Gaithel L. Simpson, M.D., Greenville, President-Elect
Kentucky State Medical Association, Presiding

1:45 p.m. **"Your American Medical Association"**
Joe D. Miller, Chicago, AMA Division of Field Service

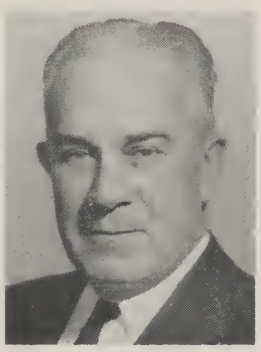
1:55 p.m. **"The Choice Is Ours"**
Mr. Roger Fleming, Washington, D. C., secretary-treasurer and director, Washington Office, American Farm Bureau Federation

2:30 p.m. **Questions and Answers**

Adjournment



Mr. Watts



Dr. Welch



Dr. McKeown



Mr. Miller

Society Officers Conference

(Continued from Page 270)

McKeown is nationally known to the profession as secretary-treasurer and a member of the Board of Trustees of the AMA, and chairman of the AMA's committee studying disciplinary problems. He is also a member of the Sears Foundation Advisory Board and the AMA's Council on Medical Services. Active in organized medicine and civic affairs, he has served as president of the Oregon State Medical Society and as mayor of his home town and president of its Chamber of Commerce. He is a graduate of the University of Toronto Faculty of Medicine.

JOE D. MILLER, Chicago—A native Kentuckian, Mr. Miller needs no introduction to KSMA members. As AMA field representative since September, 1959, he makes frequent trips to Kentucky and the four other states assigned to him. In August, 1949, Mr. Miller was named administrative assistant with the Kentucky State Tuberculosis Commission, moving up to executive director in November, 1951. In May, 1957, he joined the AMA as research associate for the Council on Medical Services. He is a graduate of the College of Commerce, University of Kentucky, and saw 33 months service as a paratrooper in World War II.

NORMAN A. WELCH, M. D., Boston—Well known New England internist, Doctor Welch was elected speaker of the AMA House of Delegates in June, 1959, after serving as a member since 1951. He was clinical professor of medicine at his alma mater, Tufts College Medical School, from 1943 to 1957, after serving as instructor in medicine at Boston University School of Medicine from 1933 to 1943. Doctor Welch has been president of the Massachusetts Medical Service (Blue Shield) since 1950 and was chairman of the National Blue Shield Commission from 1955 to 1958. He has been a member and chairman of the Massachusetts Approving Authority for Nurses and Attendant Nurses Training School. He is a past president of the New England Medical Society.

JOHN C. WATTS, Nicholasville—Congressman Watts has been in public life since his election in 1929 as Nicholasville police judge. He next served three full terms as county attorney. In 1947, he was elected to the Kentucky State Legislature and served as majority floor leader in the House of Representatives. He was Commissioner of Motor Transportation for the State of Kentucky from 1948 to 1951. Elected to the 82nd Congress at a special election on April 14, 1951, he has been successful in his bid for re-election to all succeeding Congresses. His political service includes 24 years as county chairman of his party for Jessamine County. Congressman Watts received his law degree from the University of Kentucky in 1927.

The KSMA Board of Trustees will meet the afternoon before the Conference at 4 P.M. Eastern Standard time at the Pheonix.

KSMA President to Speak In April At Three District Meetings

Three KSMA Trustee District meetings have been planned in April, which will be held as follows:

14th District—Paintsville Country Club; 3 p.m. Wednesday, April 19; William C. Hambley, M.D., Trustee.

13th District—Henry Clay Hotel, Ashland; 2 p.m. Thursday, April 20; Charles B. Johnson, M.D., Trustee.

11th District—Richmond Country Club; 2 p.m. Thursday, April 27; Hubert C. Jones, M.D., Trustee.

KSMA President Richard G. Elliott, M.D., Lexington, will speak at each of these meetings following the dinner, except in the 13th District where he'll talk in the late afternoon. Wives of members of the three districts are urged to be present.

Scientific speakers for two of the meetings will be presented under a grant-in-aid from the Merck, Sharp and Dohme Postgraduate Program. The 14th District will hear Jack Crowell, M.D., Jackson, Miss., associate professor of the Department of Physiology and Biophysics, University of Mississippi School of Medicine. He will discuss "Anti-Coagulants."

The 11th District essayist will be J. Neal Middelkamp, M.D., St. Louis, of the Department of Pediatrics, Washington University School of Medicine. His subject will be "Meningitis In Infants and Children."

At press time, the full scientific programs had not been announced. Each member will receive a program with the KSMA notice of the Meeting.

KSMA Members Are Reminded Of Dues Deadline April 1

April 1 is the deadline for payment of 1961 dues, KSMA President Richard G. Elliott, M.D., Lexington, has pointed out.

In a friendly reminder to members, Doctor Elliott thanks those who have already sent their remittances for county, state and AMA dues to the KSMA Headquarters Office, and requests the early cooperation of others.

He calls attention to Section 2, Chapter VIII, of the 1960 Bylaws which reads: "Any component society which fails to pay its assessments, or make the report as required, on or before the first day of April in each year, shall be held as suspended and none of its members or delegates shall be permitted to participate in any of the business or proceedings of the Association or of the House of Delegates until such requirements have been met."

Dr. McClure Teaching Law Medicine

G. David McClure, M.D., Louisville eye specialist, is instructor of a course in "Law Medicine" offered as a part of the spring-semester program of continuing legal education for lawyers at the University of Louisville. His class, which meets from 6:30 to 8:20 p.m. on Thursdays, began February 2 and will continue through May 18. Doctor McClure has a law degree and is chairman of the Louisville Law-Science Foundation.

AMA to Hold Medicolegal Meeting In Louisville April 14-15

Some 400 physicians and attorneys from 16 states are expected to attend a regional medicolegal conference at the Kentucky Hotel in Louisville April 14-15. Sponsor is the AMA's Legal and Socio-Economic Division, of which C. Joseph Stetler, Chicago, is director. Mr. Stetler was a participant in the 1960 County Society Officers Conference in Owensboro.



Mr. Stetler

The meeting will open at 1:30 p.m. Friday, April 14, and close at 4:40 p.m. Saturday, April 15. One half-day will be devoted to developments and trends in judicial procedures. Another half-day session will deal with a discussion of the most important cases in the medicolegal field during the past 18 months.

The Friday afternoon program will open with a talk by Edward J. McCormick, M.D., Toledo, Ohio, a past president of the AMA. His subject will be "Status of Medicolegal Cooperation."



Dr. McCormick

Featured speakers will include Crawford Morris, Cleveland, authority on Res Ipsa Loquitur; Lou Ashe, San Francisco, past president of the National Association of Claimants' Compensation Attorneys, and Judge Irving Goldstein, Skokie, Ill., an expert on medical trial technique.

The conference is one of three medicolegal meetings being sponsored by the AMA this year. Others will be held in San Francisco, March 10-11, and in New York, April 28-29.

The Louisville meeting will draw registrants from Kentucky, Tennessee, Indiana, Illinois, Ohio, West Virginia, Virginia, North Carolina, Georgia, Alabama, South Carolina, Mississippi, Arkansas, Missouri, Wisconsin and Florida.

Registered to Vote In May Primary? March 25 Is the Deadline

Are you and members of your family registered to vote in the May 23 Primary? If not, you have only until March 25 to qualify as voters.

Persons who have not voted during the past two years, who have changed their names, or who have moved from one precinct to another are required to re-register. In Kentucky, a voter must be a resident of the state for one year, of his county for six months and of his precinct for 60 days.

The importance to medicine of upcoming elections is stressed by George P. Archer, M.D., Prestonsburg, chairman of the KSMA Council on Legislative Activities, who urges all KSMA members who are not registered to vote to do so by March 25.

Surgeons Book Six Specialists For Meeting March 24-25

Operative clinics and a symposium on cancer, featuring six outstanding surgical specialists of the nation, highlight the program arranged by the Kentucky Chapter, American College of Surgeons, for its annual meeting March 24-25 at the Brown Hotel in Louisville. Laman A. Gray, M.D., Louisville, president of the chapter, invites all physicians to attend.

There will be no registration fee. However, advance registration will be necessary to insure attendance at the operative clinics, announces J. Duffy Hancock, M.D., Louisville, publicity chairman. Doctor Hancock asks that members please read their incoming mail from the College of Surgeons for full instructions.

The Program

The meeting will open at 8 a.m. Friday, March 24, with two-hour operative clinics at the various hospitals in Louisville. Transportation to the hospitals will be provided by local physicians.

At 11 a.m., the surgeons will assemble at the Brown Hotel to hear addresses by the six guest speakers. A luncheon will follow.

The afternoon will be devoted to 10-minute papers presented by some 20 Kentucky members of the College of Surgeons. During this time, the out-of-state speakers will talk to operating-room nurses from hospitals throughout the state. A luncheon for the nurses will be given by the Kentucky Chapter.

A dinner at 6:30 p.m. for doctors and their wives will conclude the first day's activities.

The symposium on cancer is scheduled for 9 a.m. to noon Saturday, as the closing feature of the meeting.

The Speakers

The six guest speakers are:

T. Campbell Thompson, M.D., New York—Surgeon-in-chief, Hospital for Special Diseases, and clinical professor of orthopedics, Cornell University School of Medicine.

Owen Wangensteen, M.D., Minneapolis—Professor and head of the Department of Surgery, University of Minnesota.

Isidor Ravdin, M.D., Philadelphia—Vice-president and professor of surgery, University of Pennsylvania.

Milton McCall, M.D., Pittsburgh—Professor and head of the Department of Obstetrics and Gynecology, University of Pittsburgh.

Edward Parker, M.D., Charleston, S. C.—Clinical professor of thoracic surgery, University of South Carolina School of Medicine.

Frank Lathrop, M.D., Boston—Chief of Ear, Nose and Throat, Lahey Clinic.

Symposium On Infectious Diseases Set March 23 In Louisville

The Louisville Pediatric Society and the University of Louisville Pediatric Department have announced a symposium on infectious diseases to be held Thursday, March 23, at the Sheraton Hotel in Louisville. Medical specialists from both coasts are on the program.

All physicians are invited, and no fee will be required for attendance at the scientific sessions, luncheon or reception. Registration will start at 9 a.m. and continue throughout the day.

John Larson, M.D., president of the Louisville Pediatric Society, and James W. Bruce, M.D., clinical professor of pediatrics at the U. of L. School of Medicine, will serve as moderators at the morning and afternoon sessions, respectively.

The complete program follows:

Morning

10:00 a.m. "New Vaccines for Measles"—Samuel L. Katz, M.D., associate in pediatrics, Beth Israel Hospital, Boston, Mass.

10:40 a.m. "Evaluation of New Antibiotics"—Ernest Jawetz, M.D., professor of microbiology and lecturer in medicine and pediatrics. University of California Medical Center, San Francisco.

11:20 a.m. Questions and Panel Discussion—Moderator, Alex Steigman, M.D., chairman. Department of Pediatrics, U. of L. School of Medicine.

12:30 p.m. Luncheon for physicians and wives—Chairman, Elliott Podoll, M.D., public relations chairman, Louisville Pediatric Society.

Afternoon

2:00 p.m. "Septicemias In Childhood" Harry C. Shirkey, M.D., associate professor of pediatrics, University of Alabama Medical College, Birmingham.

2:40 p.m. "Treatment of Viral Infections" — Edward C. Curnen, Jr., M.D., Carpentier professor of pediatrics, College of Physicians and Surgeons, Columbia University, New York.

3:20 p.m. Coffee.

3:35 p.m. Questions and Panel Discussion—Moderator, Doctor Steigman.

4:45 p.m. Reception.

Category I credit approval has been applied for.

Immunization Week May 7-13 Aimed At Six Diseases

The week of May 7-13 has been designated as "Immunization Week In Kentucky," with its annual drive for complete immunization in the state against polio, diphtheria, pertussis, tetanus, smallpox and typhoid.

The cooperation of all KSMA members in making the week a success is urged by Delmas M. Clardy, M.D., Hopkinsville, chairman of the KSMA Committee on Public Health and Prevention of Highway Accidents. Special bulletins will be mailed to physicians requesting them to check the immunization status of all members of families under their care, with special emphasis given to children.

The annual effort is sponsored by KSMA and other state-wide organizations. Many of the groups put on special programs during May to point up the special week.

KIMA Clinical Meeting Set April 7 At G. E. Appliance Park

The Kentucky Industrial Medical Association will feature a panel on "When Should My Patient Return to Work" at a clinical meeting March 23 at General Electric Appliance Park, Buechel. All persons interested in industrial medicine and surgery are invited to attend, announces Arthur J. Shulthise, M.D., Louisville.

The meeting will open with registration from 1 to 1:30 p.m. in Monogram Hall. This will be followed by a plant film at 1:30 and a plant tour from 2 to 3:30. The scientific session will begin at 3:45.

Moderator of the panel will be William E. Powles, M.D., Industrial Mental Health Project, University of Cincinnati. The three panelists and their subjects will be: C. Anthony D'Alonzo, M.D., E. I. duPont de Nemours and Company, Indianapolis, "When the Cardiac Returns to Work"; Kearns R. Thompson, M.D., Lexington, "When the Sore-back Returns to Work," and Richard C. Swan, M.D., Delco-Remy Division of General Motors Corporation, Anderson, Ind., "The Occupational Physician Looks At the Patient Returning to Work."

Joe M. Bosworth, M.D., of the Liberty Mutual Insurance Company, Atlanta, Ga., will be the dinner speaker. His topic will be "What Does Medicine Have to Offer the Industrial Employee."

AMA Book On Medical Care Costs Mailed to KSMA Members

The true story of medical care costs is told in a colorful, illustrated booklet just published by the American Medical Association for distribution to the profession. Titled "The Cost? Of Medical Care," the 16-page publication presents in cartoon form statistics that every physician should have at his fingertips to pass alone to his patients.

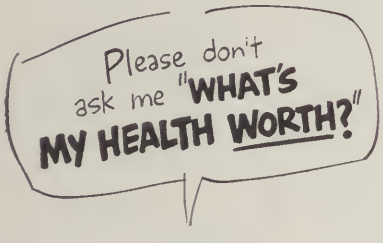
A complimentary copy, together with information on how to get additional books, is being mailed to each physician in Kentucky by the KSMA Council on Communications and Public Service, which described the pamphlet as "excellent material for your waiting room."

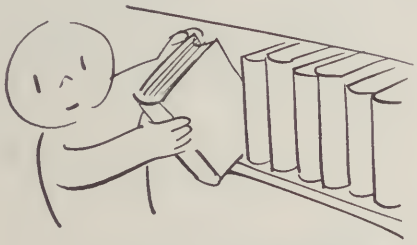
"We in medicine have the obligation to see that our patients get the true facts on this matter," said N. L. Bosworth, M.D., Lexington, chairman of the Council, in urging KSMA members to order extra copies for their offices.

Four pages from the booklet are reproduced in the following layout.

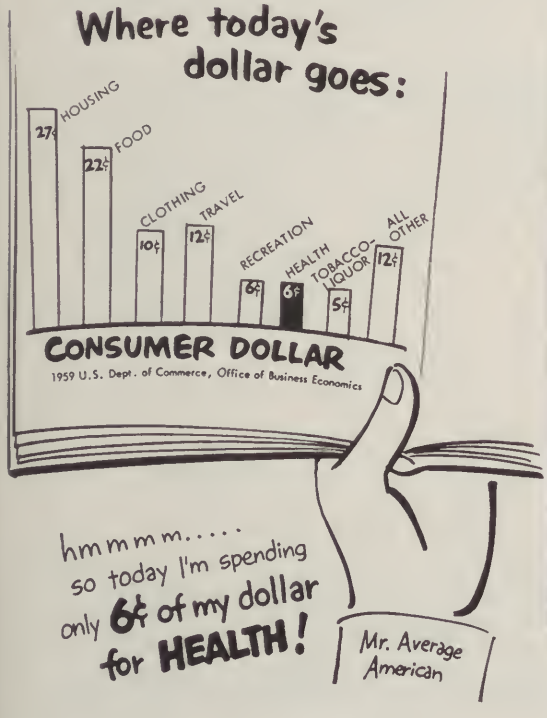
The ? cost of Medical Care...

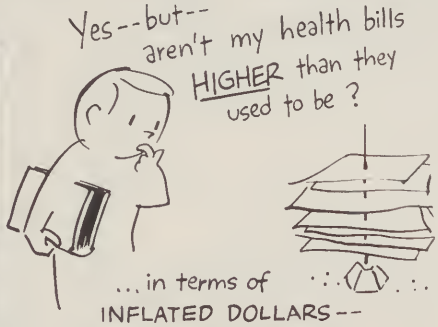
In a quandary trying to explain medical care costs in the light of today's over-all rising prices? If so, you'll be interested in these pages from the American Medical Association's new booklet "The ? Cost of Medical Care." This 16-page cartoon pamphlet is being distributed through your state medical society.



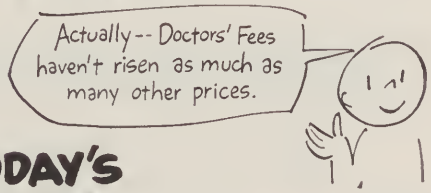


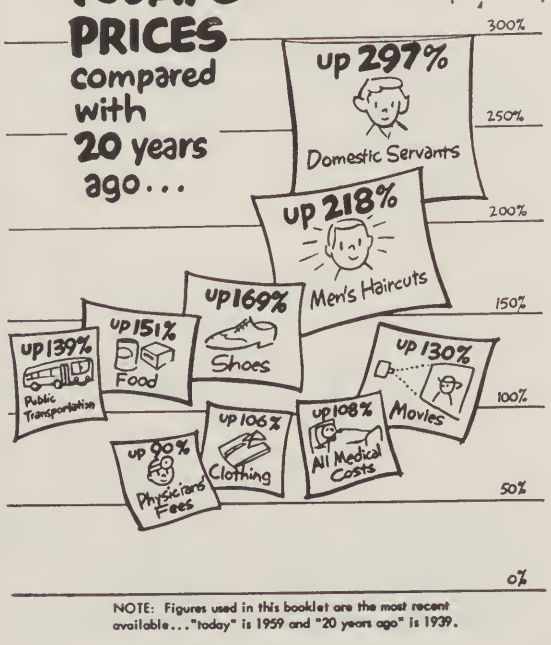
I know my health is a priceless asset.
If I'm sick, I want the best care there is.
But is medical care taking
a bigger bite out of my dollar?
That's what I'd like to FIND OUT.....



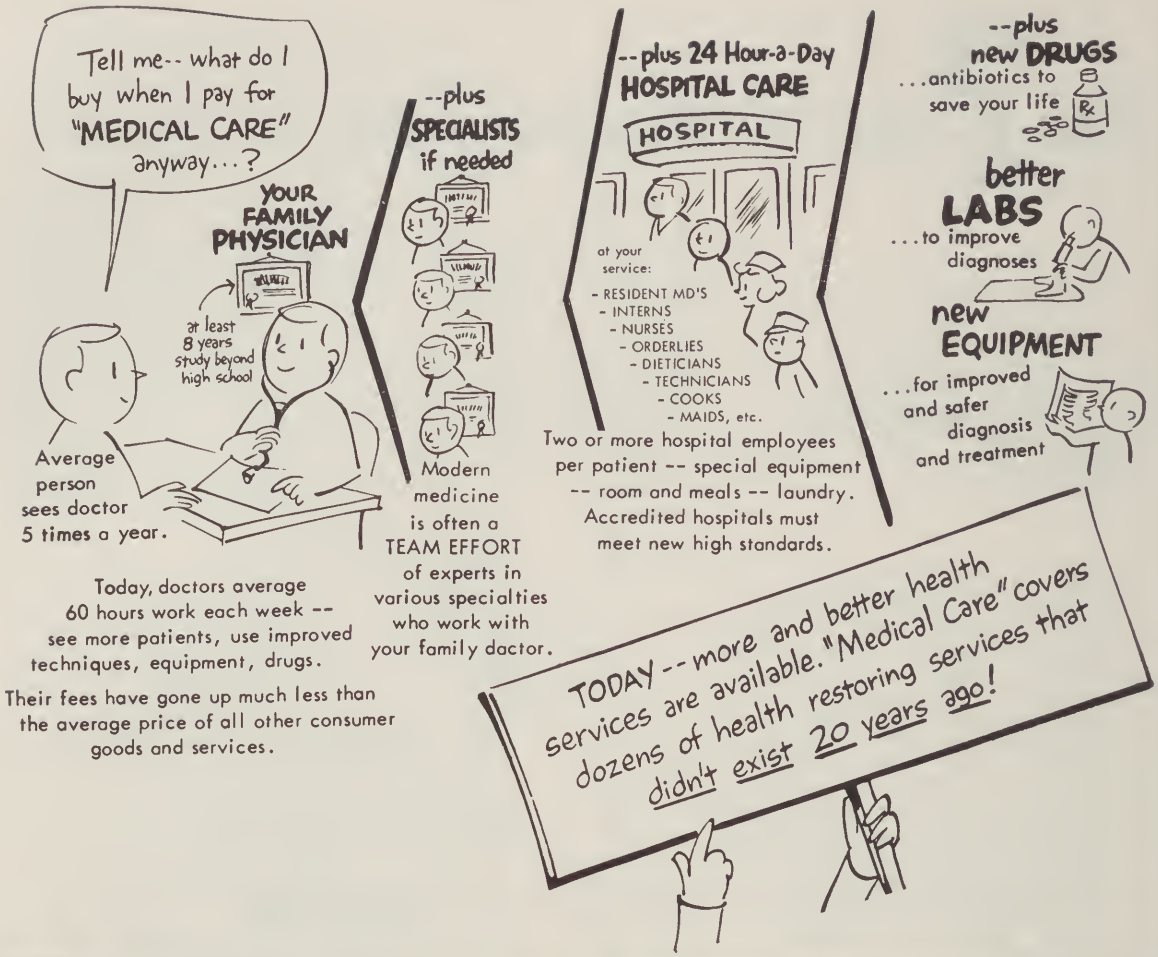


...in terms of INFLATED DOLLARS--
yes, like everything else...but
let's compare the PERCENTAGE
of increase in the prices of
some things **today** with
20 years ago!

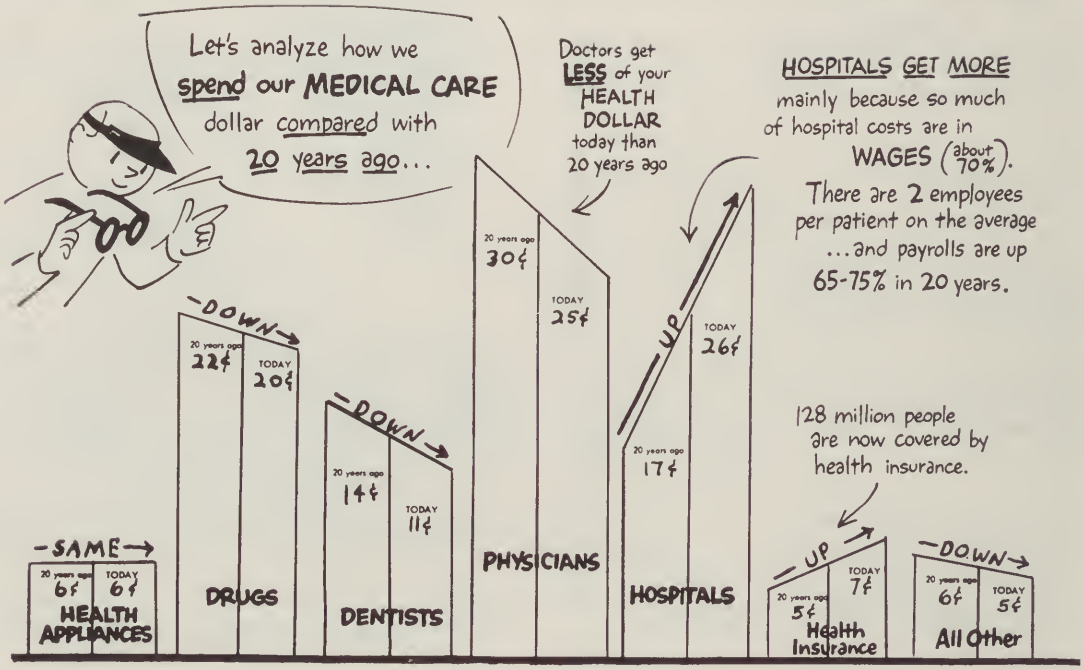




NOTE: Figures used in this booklet are the most recent available..."today" is 1959 and "20 years ago" is 1939.



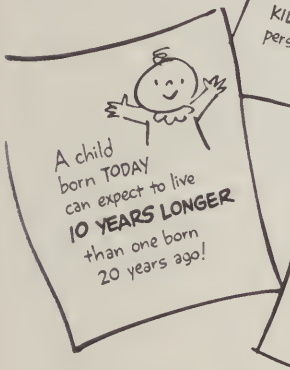
EACH DOLLAR SPENT FOR MEDICAL CARE

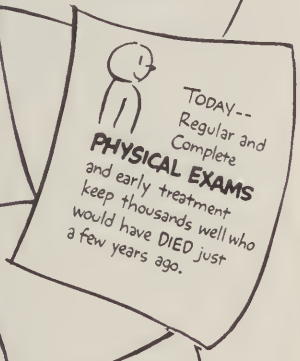


Meanwhile--in the last 20 years--
MEDICAL SCIENCE
has been making
SPECTACULAR PROGRESS--

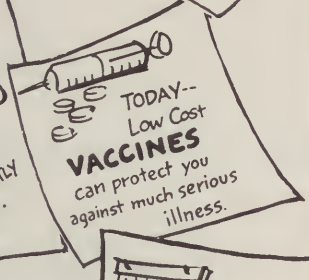


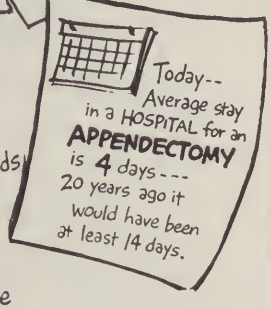
Today--New **ANTIBIOTIC DRUGS** prevent PNEUMONIA that used to KILL 1 in every 3 or 4 persons it attacked.















How can the average person **AFFORD** today's Medical Super-Care?

ANSWER: INSURANCE--72% of the total population and 49% of those over 65 today have....

VOLENTARY HEALTH INSURANCE

...which helps you pay your expenses for those UNFORESEEN HEALTH PROBLEMS.

Because people can't choose when they'll be sick, or how long--INSURANCE is the logical answer.

4 types of Voluntary Health Insurance

BLUE SHIELD

...pays your doctor for medical and surgical services. Gives you free choice of doctor.

BLUE CROSS

...pays hospital bills for board, room and special hospital services. Gives you free choice of hospital.



INSURANCE COMPANY CONTRACTS

...usually pay you cash towards hospital, surgical and medical bills or services. Do not restrict choice of physician or hospital.



GROUP PRACTICE PLANS

...and consumer sponsored plans -- provide specified types of benefits for care rendered by physicians working in groups.

TODAY voluntary health insurance pays $5.2 billion of the health care bills of insured people. Voluntary health insurance is "good medicine" -- it prevents worry -- helps you meet cost of illness.

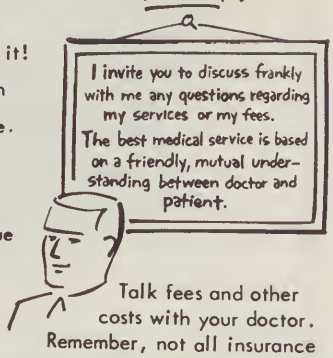
Also--as a result of medical science... TODAY--the length of time a person is ill or hospitalized is much less than 20 years ago--hence the cost of being sick or absent from work is often less--an important economic factor.

FAMILIES WITH MEDICAL EXPENSE (per year)	HOW MUCH	HOW MANY
	LESS THAN $200	68%
	$200 to $500	21%
	$500 or over	11%

How to get the **MOST** from your **Health Dollar...**

(a) Choose your **PHYSICIAN** WISELY!

The right to choose your own doctor is a precious privilege. Use it! Choose a physician in whom you have confidence. He will give you personalized health service and help you get more value for your health dollar.



Talk fees and other costs with your doctor. Remember, not all insurance contracts are designed to pay doctor's total fee, nor intended to cover total medical and hospital charges. If you cannot pay in full, tell the doctor and he may be able to work out a plan for deferred or adjusted payments.

(b) Choose your **HEALTH INSURANCE** WISELY!

Can you choose and change doctors?

Can you choose and change hospitals?

Does it cover you anywhere?

Will it admit you to most hospitals?

Does it cover most common major illnesses?

Does it cover outpatient surgery, diagnostic and laboratory services, nursing home care, etc.?

Is it enough for big medical and hospital expenses?

Any "legal loop-holes" in contract?

Is company financially stable?



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...a new public service publication for state and county medical societies from AMA.

A Scriptographic booklet designed by the Channing L. Bete Co., Inc., Greenfield, Mass.

Full Schedule Arranged By KSMA For Senior Day March 20

The many facets of medical practice will be explored for senior medical students at the University of Louisville School of Medicine on Monday, March 20 —the date of the KSMA annual Senior Day in Louisville.

Cooperating in these activities are the Jefferson County Medical Society and the U. L. medical school.

A full schedule of orientation is planned by the KSMA Senior Day Committee, headed by Carl C. Cooper, M.D., Bedford. This will be climaxed by a social hour and dinner with the Jefferson County Society as host. Guest speaker will be Chester Lauck, the former "Lum" of radio and movie fame, who is now executive assistant of the Continental Oil Company, Houston, Texas. Daniel Costigan, M.D., president of the society, invites all KSMA members to attend.

The day's program calls for the students to assemble at 12 noon in the Rankin Amphitheatre of Louisville General Hospital to hear an address by Richard G. Elliott, M.D., Lexington, KSMA president. His topic will be "What's In Organized Medicine For Me?"

The afternoon session, to be held in Parlors B and C of the Kentucky Hotel, will be called to order by Doctor Cooper at 2:30 p.m. The complete program follows:

"Bridging the Gap"—Oscar J. Hayes, M.D., Louisville.

Panel, "Where You Practice"—Carl Fortune, M.D., Lexington, moderator; Jack L. Chumley, M.D., Louisville; Lillard F. Beasley, M.D., Franklin, and Garnett J. Sweeney, M.D., Liberty.

"The Mechanics of Setting Up a Practice"—John W. Ratliff, Jr., M.D., Lebanon.

"The AMA and You"—Joe D. Miller, Chicago, field representative, AMA.

Panel, "Human Equation In Medical Practice"—Wyatt Norvell, M.D., New Castle, moderator; Donald Chatham, M.D., Shelbyville; J. A. Bishop, M.D., Jeffersontown, and George W. Pedigo, M.D., Louisville.

"Economics of Medicine"—Edward B. Mersch, M.D., Covington.

"What Blue Cross-Blue Shield Means to You"—Ed McConnell, Louisville, vice-president, Blue Cross.

"This Above All"—Orson P. Smith, Jr., M.D., Louisville.

The social hour and dinner will be held in the Kentucky Hotel Terrace Room.

KSS to Meet May 13 In French Lick

The Kentucky Surgical Society will hold its 1961 annual meeting in French Lick, Ind., on Saturday, May 13, according to C. Melvin Bernhard, M.D., Louisville, secretary-treasurer. The sessions will be held at the Sheraton Hotel.

Arrangements for the meeting are in charge of the program committee headed by Rudolf J. Noer, M.D., Louisville, professor and chairman of the Department of Surgery, University of Louisville School of Medicine.



A SCALE MODEL of a 200-bed emergency hospital, on display at the three-day Health Mobilization Training Conference held in Frankfort January 24-26, is discussed by four participants in the course, from left: H. G. Sargent, M. D., health officer for Ballard and McCracken counties; Norman R. Tufts, M.D., chief of the Health Mobilization Training Section, Training Branch, Communicable Disease Center, Atlanta; Robert Smith M.D., deputy chief of the Division of Health Mobilization, Public Health Service, Washington, and William E. Rudd, Louisville, representative of the Kentucky State Medical Association. There are 21 such hospitals stored in Kentucky ready for emergency use.

120 Attend Health Mobilization Training Course In Frankfort

Approximately 120 persons attended a three-day Health Mobilization Training Course in Frankfort, January 24-26, sponsored by the Kentucky State Department of Health. Invited were health officers, physicians, nurses, sanitarians and others interested in this phase of civil defense.

Emphasis of the course was directed toward the mobilization of health facilities in case of thermonuclear attack. Also stressed was the necessity of setting up the civil defense structure prior to an attack to enable a workable plan to be put quickly in operation.

Noting that over a half of the total national budget is now allocated for defense, Kirk T. Mosley, M. D., Commissioner of the Oklahoma State Health Department, stated that this should show vividly that war is not outmoded and that the United States should be working actively toward minimizing losses in case of attack.

On the concluding day of the course, all in attendance were presented certificates by the Governor's office showing they had participated in such a conference.

E. Dargan Smith, M.D., Owensboro surgeon for 32 years, has been appointed health officer of Daviess, McLean and Hancock Counties. He began his new duties February 1. A 1915 graduate of the University of Louisville School of Medicine, Doctor Smith practiced in China for six years before locating in Louisville. From there he went to Owensboro in 1928.

KAGP's 10th Annual Meeting Set May 10-12 In Louisville

The Kentucky Academy of General Practice will present 10 medical authorities from eight states at its 10th annual scientific assembly May 10-12, according to the program arranged by the group's commission on scientific assembly headed by Robert M. Sirkle, M.D., Lexington. The meeting will be held at the Kentucky Hotel in Loiusville.

Following registration at 7:30 a.m. Wednesday, May 10, the assembly will officially open at 8:45 with a 15-minute program of welcome to members and guests. Participating in the ceremony with KAGP president John G. Archer, M.D., Prestonsburg, will be James W. Davis, M.D., Louisville, president of the Jefferson County Academy of General Practice, and Richard G. Elliott, M.D., Lexington, president of the Kentucky State Medical Association.

Wednesday

The scientific session will start at 9 o'clock, with four essayists scheduled for morning and afternoon presentations:

Mark M. Ravitch, M.D., Baltimore—"Hiatus Hernia of the Esophagus" and "Current Tendencies In the Treatment of Peptic Ulcer."

Herbert O. Sieker, M.D., Durham, N. C.—"Immune Mechanisms As a Cause of Disease" and "Pulmonary Diseases of Allergic Origin."

Karl J. Karnaky, M.D., Houston, Texas—"Cause and Treatment of Leukorrheas" and "Endocrine Therapy for Gynecological Disorders."

Harold A. Sofield, M.D., Oak Park, Ill.—"The Treatment of Common Fractures" and "Diagnosis and Treatment of Common Backaches."

Thursday

Speakers for Thursday, May 11, and their subjects are:

Max S. Sadove, M.D., Chicago—"The Management of Pain" and "Narcotics—Their Use and Abuse."

John B. Montgomery, M.D., Philadelphia—"Abortion Problem-Diagnosis and Management" and "Management of Pelvic Floor Relaxation and Uterine Displacement."

O. F. Rosenow, M.D., Columbus, Ohio—"Diagnostic Hints In Medicine" and "Therapeutic Hints In Medicine."

Robert G. Ellison, M.D., Augusta, Ga.—"The Management of Non-Penetrating Injuries of the Chest" and "Cardiac Surgery in the Newborn."

Friday

The closing half-day session on Friday, May 12, will have as essayists:

Randolph Batson, M.D., Nashville, Tenn.—"The Neurologically Damaged Child" and "Birth Defects In Children."

Valdemar M. Jordan, M.D., Cleveland, Ohio—"Hearing Defects In Children Under Five" and "Recent Advances In Reconstructive Ear Surgery In Children."

APHA Southern Branch, KPHA Meet In Louisville In April

The Kentucky Public Health Association has scheduled its 13th annual meeting April 11 in Louisville, as a prelude to the 29th annual meeting of the Southern Branch, American Public Health Association, April 12-14. All sessions will be held at the Kentucky Hotel, according to KPHA president Miss Ruth Spurrier, Frankfort, of the State Department of Health.

Official hosts will be Russell E. Teague, M.D., Frankfort, State Commissioner of Health, and Maurice E. Kamp, M.D., Louisville, Jefferson County health officer.

The keynote speaker will be William F. Mayes, M.D., director of Community Health Practice, U. S. Public Health Service, Washington, D. C. His address is scheduled for Wednesday morning, April 12.

"The Growing Pace of Public Health—Guidelines for the Future" is the theme adopted for the meeting.

Pediatric Journal Devotes Issue To Louisville Physicians

Louisville physicians can take credit for the February issue of *Pediatric Clinics of North America*, a quarterly publication.

Edited by Alex J. Steigman, M.D., professor and chairman of the Department of Pediatrics at the University of Louisville School of Medicine, the edition features 55 articles, all but three of which were written by voluntary faculty members of the medical school and other Louisville doctors. Co-editor is Keith Hammond, M.D., Muncie, Ind., who was a resident at Loiusville General Hospital when the material was prepared for publication.

The issue covers the general subjects, "Office Practice and Procedures." Most of the topics were suggested by questions asked during postgraduate courses taught by Doctor Steigman during the past 10 to 15 years.

Dr. Noer Editor of New Journal

Rudolf J. Noer, M.D., professor and chairman of the Department of Surgery, University of Louisville School of Medicine, is editor of a new medical publication, the *Journal of Trauma*. The bimonthly journal will print technical articles on the treatment of injuries where shock and trauma are involved.

Doctor Noer was named editor last October by the American Association for The Surgery of Trauma.

Seven New KSMA Members

Seven physicians have become members of KSMA since The Journal's last report. They are:

W. N. Bell, M.D., Sturgis
J. L. Blackerby, M.D., Lexington
John R. Cole, M.D., Lexington
Richard E. Mudd, M.D., Louisville
Fred D. Owen, M.D., Franklin
Hugh A. Starrow, M.D., Lexington
Emmett Wood, M.D., Bardstown

KSMA's Views On Indigent Medical Care Go to Governor's Council

Recommendations of the KSMA Board of Trustees for improvement of operating procedures of Kentucky's new indigent medical care program have been considered by the KSMA Technical Advisory Committee to the Governor's Advisory Council on Indigent Medical Care.

The committee's actions on the recommendations were being forwarded to the Governor's Council as The Journal went to press, so a report could not be made in this issue. A summary of the results of these efforts will be carried in a later issue.

In a day-long session on January 26, the Board of Trustees heard the objectives and recommendations on the new indigent medical care program from 10 different medical groups. Six appeared in person, leaving written statements, while four sent their statements to the Board.

Following a question-and-answer session, the guests were excused and the Board went into executive session. It then reviewed the Association's interest in the program since the beginning back in 1952 until the present.

After full and thoughtful consideration by the Board, the following action was voted:

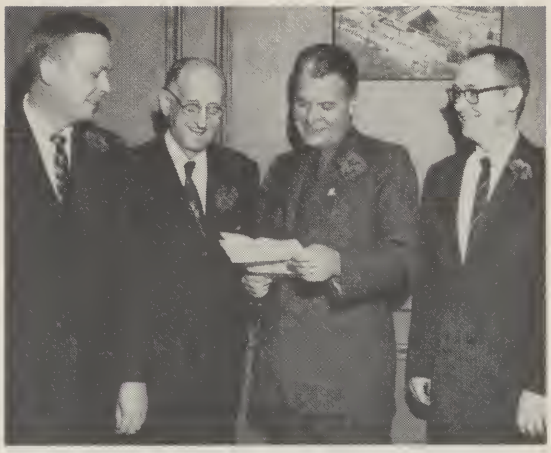
"That the Technical Advisory Committee of KSMA to the Governor's Council on Indigent Medical Care be directed to recommend to the Advisory Council that the normal going fee of the physicians in their local community be charged for services rendered under the Indigent Medical Care Program and that physicians be paid on a proportionate basis out of the funds set aside for physicians under the program after the end of each month."

In addition, the Board gave members of the Technical Advisory Committee and the Governor's Advisory Council a complete vote of confidence. "The Board also voted to call your attention to the fact that this program was enacted by the 1960 session of the General Assembly, that it is law, and that the trustees of KSMA are not 'running the show,' but through advisory channels set up by the law are doing the best they can to develop an equitable program."

The Board also pointed out "that, because of circumstances beyond the control of the Technical Advisory Committee or the Association's representative on the Governor's Council on Indigent Medical Care, it is not possible to distribute adequate information to the individual physicians up to the present time."

To acquaint all KSMA members of the Board's January 26 actions, a summary of the recommendations, together with a four-page folder giving supplemental information, was sent to each member on February 2. If you have misplaced your copy, a duplicate may be obtained by writing the KSMA Headquarters Office.

Plan to attend the County Society Officers Conference in Lexington, April 6.



MERIT SYSTEM coverage has been extended to the approximately 580 employes of the State Tuberculosis Hospital Commission, the first agency to certify its readiness to come under the merit system law passed by the 1960 General Assembly. The announcement was made at Frankfort by, from left, Personnel Commissioner Walter Gattis; C. C. Howard, M. D., Glasgow, chairman of the TB Hospital Commission; Governor Bert T. Combs, and Thomas M. Layton, executive director of the Commission. "The merit system," the Governor said, "is designed to cut down expensive turnover in State personnel and to protect State employes from political interference."

U. L. Medical School News

John Fuller Taylor, M. D., professor and chairman of the Department of Biochemistry, University of Louisville School of Medicine, has been granted a six-month leave of absence for study abroad. The recipient of a Commonwealth Fund fellowship, Doctor Taylor will leave in July to do research at Cambridge University in England and at the University of Rome in Italy. He also plans to attend the Fifth International Biochemical Congress in Moscow and the First International Biophysical Congress in Stockholm.

A $49,680 research grant has been awarded **Gasper Carrasquer, M.D.,** instructor at the University of Louisville School of Medicine, by the National Institutes of Health. Doctor Carrasquer, who graduated from medical school in Valencia, Spain, will use the funds for a three-year study of the human kidney.

Appointment of **R. D. Brooke Williams, M.D.,** as instructor of pediatrics at the University of Louisville School of Medicine, effective April 1, has been announced by the university's board of trustees. Doctor Williams has been in private practice in Rochester, N.Y., for eight years.

Ob-Gyn Meet In Cincinnati In May

The Kentucky Obstetrical and Gynecological Society has scheduled its 14th annual meeting in Cincinnati, May 18-20. The sessions will be held in the Netherland Hilton Hotel.

Essayists will include top Ob-Gyn specialists from Kentucky and Ohio, according to John H. Siehl, M.D., Covington, president of the society. The complete program will appear in the April issue of The Journal.

Kentuckians Attend AMA Congress On Education, Licensure

Kentucky was well represented at the 57th Annual Congress on Medical Education and Licensure held in Chicago, February 4-7, under auspices of the AMA's Council on Medical Education and Hospitals and Advisory Board for Medical Specialties. Meeting in conjunction with the congress was the Federation of State Medical Boards of the United States.

The program was devoted to four major topics, opening with "The Future of Family Practice." The other subjects to which half-day sessions were assigned were:" Is There Danger of Losing An Appropriate Balance Between the Basic and Clinical Sciences In Medical School?" "The Support of House Officer Training Programs" and "Medical Care and Education In Hospitals Without Interns Or Residents."

Making up the Kentucky delegation were the deans of the state's two medical schools, J. Murray Kinsman, M.D., University of Louisville School of Medicine, and William R. Willard, M.D., University of Kentucky College of Medicine; Russell E. Teague, M.D., Frankfort, State Commissioner of Health; Edmund D. Pellegrino, M.D., and James A. Halsted, M.D., Lexington; Carroll L. Witten, M.D., Louisville; David M. Greeley, M.D., Harlan, and William E. Rudd, of the KSMA Headquarters staff.

Doctor Willard is a member of the AMA Council on Medical Education and Hospitals, which devotes a majority of its time to medical-school activities and programs designed to further postgraduate medical education. It also works with the allied professions in continuing education.

Paducah Medical Careers Program Attracts 130 Students

Medical Careers Day attracted approximately 130 seniors from 10 Western Kentucky high schools to Paducah Monday afternoon, February 13, for a special program sponsored by the McCracken County Medical Society and the Tilghman High School. Invitations had been issued to high schools in nine counties.

William R. Willard, M.D., dean of the University of Kentucky College of Medicine, challenged the students to seek the rewarding careers offered in the medical field. Citing the urgent need for more physicians, dentists, nurses, medical technicians and teachers, he also called attention to opportunities offered by others of the some 50 groups allied to medicine. By 1975, he said, 50 per cent more physicians and 32 new medical schools will be needed to take care of the exploding population.

As for the chances of being accepted by a medical school, Doctor Willard said that about half of the applicants will be admitted. He emphasized that student loans and scholarships are available for worthy and well-qualified students.

Harry Abell, M.D., president of the McCracken County Medical Society, presided at the meeting which was held in the Tilghman auditorium. Bradford Muntcher, principal of the school, welcomed the students and their teachers, and Leon Higdon, M.D., chairman of the KSMA Advisory Committee to the University of Kentucky, introduced the speaker.

Bobbie R. Grogan, Louisville, director of field services for KSMA, explained the Rural Kentucky Medical Scholarship Program to the students.

The idea for the program originated with J. Vernon Pace, M.D., Paducah, KSMA delegate to the AMA, and Walter Jetton, retired principal of Tilghman High School.

State Narcotic Law Unaffected By New Federal Regulations

New federal regulations exempting certain narcotic preparations have no effect on state law, the Division of Investigation and Narcotic Control has pointed out in a memorandum to pharmacists. The preparations are divided into two classes, known as Class M and Class X.

Martin Niswonger, director of the Division, explains it this way: "Insofar as the state law is concerned, none of these preparations may be sold without a prescription, except medicinal preparations that contain in one fluid ounce, or if a solid or semi-solid preparation, in one avoirdupois ounce, not more than one grain of codeine or any of its salts, and containing some drug or drugs conferring upon it medicinal qualities other than those possessed by the narcotic drug alone."

There are, however, many narcotic preparations that may be legally prescribed orally by a licensed practitioner over the telephone, under the provisions of the law of Kentucky, Mr. Niswonger said. A list of the narcotic drugs and compounds for wihch oral prescription is authorized may be obtained by writing to the Division of Investigation and Narcotic Control, State Department of Health, Frankfort. Ask for information provided under Form KRS 218,060.

Physicians Reminded Of Devices For Indigent Arthritics

Indigent arthritics in Kentucky are not taking full advantage of the loan bank of self-help devices started last March by the Kentucky Chapter, Arthritis and Rheumatism Foundation, according to Gordon Huff, executive director of the organization. The greatest demand to date has been for wheel chairs and walkers.

However, Mr. Huff points out that there are many other loan-bank devices scattered all over Kentucky, which are available to indigent patients. A physician need only certify that a patient is in need and is unable to buy or rent the device. The list of devices includes bath seats, canes, crutches, door pulley assemblies, hand exercisers, hand grips, heat lamps, rollamodes, shoulder wheels, thera-plast, traction sets, vibra baths, utensil holders, button hooks, overhead bed frames, body heaters and horseshoe cushions.

Further information about the loan bank may be obtained by writing the Kentucky Chapter, ARF, 211 Speed Building, Louisville 2, Ky.



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DOSAGE: The recommended initial dosage for adults is two tablets (2.5 mg. each) three or four times daily, reduced to meet the requirements of each patient as soon as the diarrhea is under control. Maintenance dosage may be as low as two tablets daily. Lomotil, brand of diphenoxylate hydrochloride with atropine sulfate, is supplied as unscored, uncoated white tablets of 2.5 mg., each containing 0.025 mg. ($\frac{1}{2400}$ grain) of atropine sulfate to discourage deliberate overdosage.

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KSMA Council, Committee Reports

Advisory Commission to Blue Shield

W. Vinson Pierce, M.D., Covington, Chairman

Louisville **February 16, 1961**

Seventeen persons, including three guests, attended the meeting of the Advisory Commission to Blue Shield at the Blue Cross-Blue Shield Building on February 16.

Considerable attention was given to developing a better understanding by KSMA members of the services that Blue Shield is designed to render the patient and the physician. Also, much consideration was given to ways of increasing public understanding of the Blue Shield program.

The commission voted to encourage county medical societies to plan at least one program a year on Blue Shield matters, to which would be invited a physician member of the Board of Directors, a member of the commission, and staff members of the Blue Shield plan.

The commission voted to ask the headquarters staff of Blue Shield to make early recommendations to the commission for study on ways and means in which services provided by Blue Shield in Kentucky might be broadened. The advisory commission would then make its recommendations to the Board of Directors of Kentucky Physicians Mutual (the Kentucky Blue Shield plan) for broadening coverage.

William Buschemeyer, M.D., chairman of the Jefferson County committee on medical economics, appeared before the Board to bring the recommendations of his committee.

Building Committee

George F. Brockman, M.D., Greenville, Chairman

Louisville **January 25, 1961**

The committee, meeting in the Blue Cross-Blue Shield Building, reviewed developments in getting the lot for the proposed new KSMA building rezoned, and the purchase agreement and deed for the new property.

After careful consideration of information and material presented by the architect, the committee voted to authorize the development and completion of plans and specifications for the new building.

It was observed that the record of perfect attendance established by the committee at former meetings was kept intact.

Committee on Technical Exhibits

Donald K. Dudderar, M.D., Newport, Chairman

Covington **January 12, 1960**

The committee reviewed the records of the 1960 meeting and the report of the liaison committee of the Medical Exhibitors Association.

Plans for development of promotion for the 1961 meeting were discussed and approved. The problem of unauthorized attendance at the meetings also was discussed and remedies leading to correcting the situation were agreed upon.

Council on Communications and Public Service

N. L. Bosworth, M.D., Lexington, Chairman

Brown Hotel, Louisville **January 26, 1961**

Holding its first meeting since the new organizational setup adopted by the KSMA in September of 1960, the Council first of all thoroughly reviewed and discussed past and future activities of the seven committees serving under it.

Items referred to the Council from the 1960 session of the House of Delegates were discussed, namely the American Association of Medical Assistants and a request for physicians to list their normal charges on Blue Shield claim forms when submitting these forms to Blue Shield. It was recommended to the Board of Trustees and through the Board to the House of Delegates that this organization be approved by the KSMA. The Council was opposed to the listing of fees on the Blue Shield form and recommended to the Board of Trustees and the House of Delegates that action taken at the 1959 and 1960 sessions be reconsidered.

Also reviewed were the exhibits of KEA and the Kentucky State Fair, the Senior Day program, the New Members Welcoming Luncheon and the Practical Politics Course.

After reviewing the new AMA booklet "The Cost of Medical Care," it was recommended that a complimentary copy be sent to every physician in Kentucky.

Council on Medical Services

Claude C. Waldrop, M.D., Williamstown, Chairman

Kentucky Hotel, Louisville **January 19, 1961**

The first meeting of the Council on Medical Services under the new KSMA organizational setup devoted the majority of a lengthy afternoon session to a discussion of the indigent medical care program in Kentucky. Also discussed was the role of the committees serving under the Council.

Several of the committee chairmen presented their plans for the Associational year and announced that meetings of their committees had been called. The Insurance Committee was scheduled to meet on March 9 and the Advisory Commission to Blue Shield on February 16.

The Committee on Federal Medical Services was authorized to report directly to the Board of Trustees this year concerning the reviewing of the Hometown Medical Care Program with the Veterans Administration and the Dependents Medicare Program with the Government.

Due to the lengthy session, there was not time for discussion of the entire agenda, and the remaining items were deferred until the next meeting of the Council.

Remember the County Society Officers Conference in Lexington, April 6.

Postgraduate Medical Offerings Announced Through June

Postgraduate medical opportunities in Kentucky and adjoining states for the next three-month period are announced by the KSMA Postgraduate Medical Education Office.

Special attention is called to three postgraduate programs planned by this office. The first is a permanent opportunity at Louisville General Hospital every week during 1961. This training is in the field of OB-GYN and lasts one full week. The fee is $50, and because of the type of training offered, there will be a limitation of two physicians per week. Enrollment should be made at least two weeks in advance. The course is under the supervision of Douglas Haynes, M.D., chairman of the Department of OB-GYN at General Hospital.

The second program is an intermittent course on Pediatrics, to be held at Children's Hospital on Tuesdays from April 4 through May 23, from 9:30 a.m. to 12:30 p.m. There will be a fee of $30 for the entire course, or $5 per day.

The third offering is a tentative program on Pediatrics to be held in Owensboro on April 12 and 13.

Detailed information on the listings may be obtained from the Postgraduate Medical Education Office, 104 West Chestnut Street, Louisville 2. The telephone number is JUniper 7-7135.

The complete listing follows:

Weekly through 1961	One week training in the field of OB-GYN, each week during 1961, except April 17-29, May 15-20, October 2-7, and October 23-28, limitation of two physicians per week; fee of $50 includes room at General Hospital, if desired. Enrollment should be made at least two weeks before desired participation. KAGP Category I Credit applied for.

March

15-17	Postgraduate course, "Anesthesiology"; University of Tennessee, Memphis.
16-17	Postgraduate course, "Gastroenterology"; University of Nebraska College of Medicine, Omaha.
20	Senior Day Program — Sponsored by the KSMA, Jefferson County Medical Society, and the University of Louisville; afternoon and evening, Kentucky Hotel.
20-24	Postgraduate course, "Electrocardiography"; University of Tennessee, Memphis.
22-23	Symposium on Heart Disease, sponsored by the Heart Association, and the University of Louisville; Brown Hotel, Louisville.
23	Pediatric Society meeting; Louisville, Sheraton Hotel.
24	Postgraduate course, "Physical Medicine"; University of Nebraska College of Medicine, Omaha.
24-25	Kentucky Chapter, American College of Surgeons, Annual Meeting; Louisville, Brown Hotel.
29 through April 19	Annual Spring General Practice Review of Jefferson County Academy of General Practice; Norman Glazer, M.D.; Wednesday nights, Louisville.
30	Postgraduate course, "Obstetrics (Lincoln)"; University of Nebraska College of Medicine, Omaha.

April

3-5	Postgraduate course, "Radiology-Diagnostic"; University of Michigan Medical School Center, Ann Arbor.
4- through May 23:	Postgraduate course, "Pediatrics"; Children's Hospital, Louisville, Tuesday mornings, 9:30 to 12:30; fee, $30 for the course or $5 per day. Acceptable for KAGP Category 1 Credit of 24 hours.
5-7	Postgraduate course, "Ob-Gyn"; University of Tennessee Medical School, Memphis.
6	County Society Officers Conference; Lexington, Phoenix Hotel.
7-12	Ohio State Medical Association Annual Meeting; Netherlands Hilton Hotel, Cincinnati.
7-12	Tennessee State Medical Association Meeting; Reed House, Chattanooga.
12-13	Postgraduate course, "Pediatrics" (Tentative), Owensboro.
13-15	Postgraduate course, "Allergy"; University of Michigan Medical Center, Ann Arbor.
14-15	Medical Legal Conference, sponsored by the AMA; Louisville.
17-18	Postgraduate course, "Pediatrics"; University of Nebraska College of Medicine, Omaha.
17-21	Postgraduate Course, "Endocrinology and Metabolism"; University of Michigan Medical Center, Ann Arbor.
20-23	Postgraduate course, "Otolaryngology"; University of Michigan Medical Center.
24-26	Postgraduate course, "Rheumatology"; University of Michigan Medical Center.
24-26	Postgraduate course, "Ophthalmology"; University of Michigan Medical Center.

May

2	Postgraduate course, "Anesthesiology"; University of Nebraska, College of Medicine, Omaha.
3	Sixth Annual Trauma Day; University of Nebraska, Omaha.
4-5	Postgraduate course, "Urinary Tract Disease —Diagnosis and Treatment"; University of Tennessee, Memphis.
8-12	42nd Annual Session of the American College of Physicians; Miami Beach, Fla.
10-12	Kentucky Academy of General Practice Annual Scientific Meeting; Kentucky Hotel, Louisville.

(Continued on Next Page)

PG OPPORTUNITIES

(Continued)

May

17-18	Postgraduate course, "Neurology"; University of Tennessee, Memphis.
17-June 7	Jefferson County Academy of General Practice Spring Seminar; Wednesday nights.
24-26	Postgraduate course, "Diagnosis and Treatment—Emotional Disturbances in Children"; University of Tennessee, Memphis.
24-25	Postgraduate course, "Medicine" (Tentative); Harrodsburg, Ky.

June

6	Kentucky Academy of General Practice Seminar; Harrodsburg.
14-15	Postgraduate course, "Chest Diseases;" (Tentative), Louisville.
22	Kentucky Academy of General Practice Seminar; Henderson.
22	Joint meeting of the Fourth & Sixth Trustee Districts, Glasgow.
26-30	AMA Annual Meeting, New York City.

Charles P. Bartley, M.D., Madisonville, has been elected a Diplomate of the American Board of Orthopedic Surgery. Doctor Bartley has been associated with the Trover Clinic in Madisonville for several years.

KPS Annual Meeting April 20

The Kentucky Pediatric Society has scheduled its 1961 annual meeting for Thursday, April 20, at the Brown Hotel in Louisville. The program will start at 2 p.m.

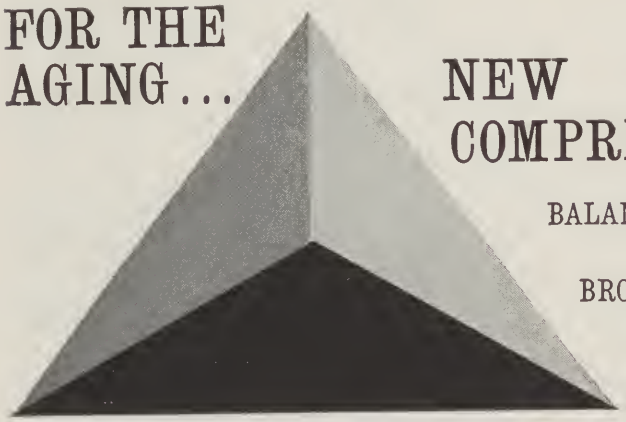
Speakers will be Robert Ward, M.D., professor of pediatrics at the University of Southern California and physician and chief of pediatrics at Children's Hospital, Los Angeles, and Samuel Kaplan, M.D., director of the Cardiology Department of Children's Hospital, Cincinnati. Doctor Ward will discuss "New Developments in Viral Hepatitis" and Doctor Kaplan will speak on "Bedside Diagnosis of Heart Disease in Children."

Dr. Haynes Supports Appeal

An appeal to the United States Supreme Court to rule Connecticut's birth-control law unconstitutional has been filed by 66 professors of obstetrics and gynecology in the country's top medical schools. In the group is Douglas M. Haynes, M.D., professor and chairman of the Department of Ob-Gyn at the University of Louisville School of Medicine.

The appeal was filed on behalf of C. Lee Buxton, M.D., of the Yale University School of Medicine and two of his patients. The Connecticut statute in question makes it illegal for a doctor to give out birth-control information or prescribe contraceptives.

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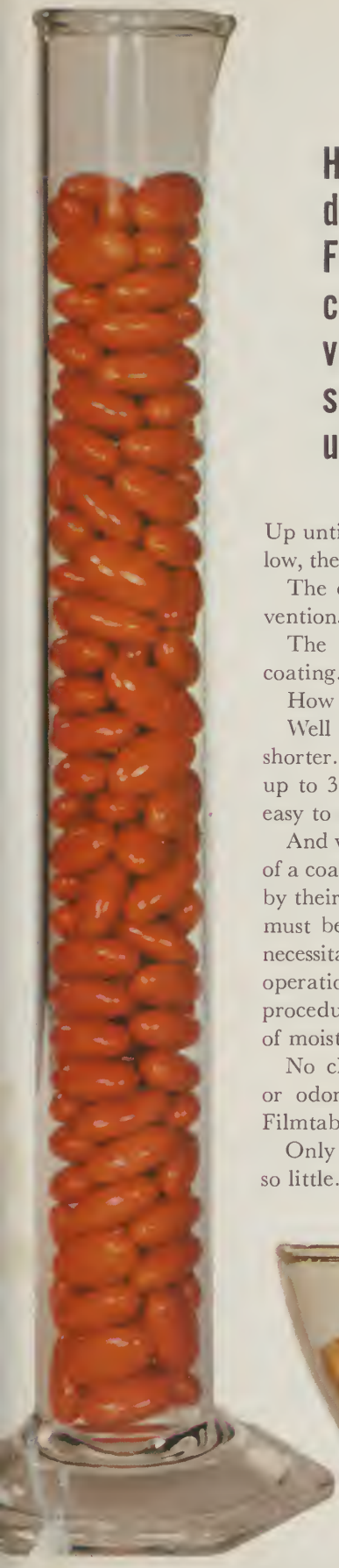
1 small capsule every morning

GEVRESTIN®

Geriatric Vitamins-Minerals-Hormones-d-Amphetamine Lederle

Each capsule contains: Ethinyl Estradiol 0.01 mg. • Methyl Testosterone 2.5 mg. • d-Amphetamine Sulfate 2.5 mg. • Vitamin A (Acetate) 5,000 U.S.P. Units • Vitamin D 500 U.S.P. Units • Vitamin B_{12} with AUTRINIC® Intrinsic Factor Concentrate 1/15 U.S.P. Unit (Oral) • Thiamine Mononitrate (B_1) 5 mg. • Riboflavin (B_2) 5 mg. • Niacinamide 15 mg. • Pyridoxine HCl (B_6) 0.5 mg. • Calcium Pantothenate 5 mg. • Choline Bitartrate 25 mg. • Inositol 25 mg. • Ascorbic Acid (C) as Calcium Ascorbate 50 mg. • l-Lysine Monohydrochloride 25 mg. • Vitamin E (Tocopherol Acid Succinate) 10 Int. Units • Rutin 12.5 mg. • Ferrous Fumarate (Elemental Iron, 10 mg.) 30.4 mg. • Iodine (as KI) 0.1 mg. • Calcium (as $CaHPO_4$) 35 mg. • Phosphorus (as $CaHPO_4$) 27 mg. • Fluorine (as CaF_2) 0.1 mg. • Copper (as CuO) 1 mg. • Potassium (as K_2SO_4) 5 mg. • Manganese (as MnO_2) 1 mg. • Zinc (as ZnO) 0.5 mg. • Magnesium (MgO) 1 mg. • Boron (as $Na_2B_4O_7.10H_2O$) 0.1 mg. Bottles of 100, 1000.

LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York



How do Filmtab® coated vitamins stack up?

Up until the moment we put the coatings on the Optilets® below, the tablets were all the same. Now, consider the differences.

The column on the left contains 125 Optilets with a conventional sugar coating.

The column on the right—125 Optilets with a Filmtab coating.

How do they stack up?

Well it's easy to see that the column on the right is much shorter. That's because the Filmtab coating cuts tablet bulk up to 30%. The result is a small, streamlined vitamin that's easy to swallow—the most compact tablet of its kind.

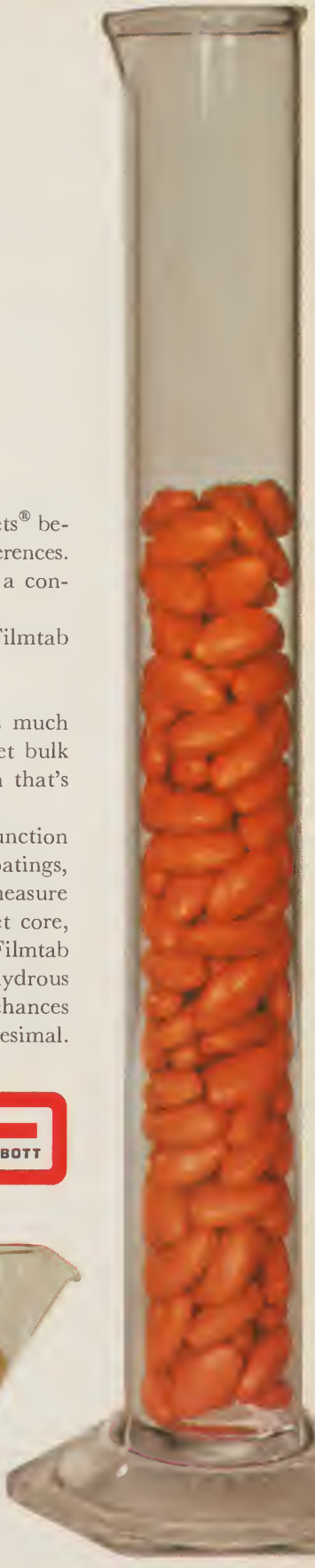
And when it comes to protecting potency (the main function of a coating), the Filmtab is in a class by itself. Sugar coatings, by their very nature, are aqueous solutions. Yet every measure must be taken to keep moisture out of the vital tablet core, necessitating "seal" coats which also increase bulk. The Filmtab operation, on the other hand, is essentially an anhydrous procedure. Seal coats are neither used nor needed. The chances of moisture being trapped inside the tablet are infinitesimal.

No chipping or breaking, no vitamin tastes or odors, no wasted vitamins—thanks to the Filmtab coating.

Only the Abbott Filmtab offers so much in so little.

ABBOTT





Filmtab—Film-sealed Tablets, Abbott.

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Abbott Vitamins Stay On the Table



...in attractive daily-reminder table-bottles

MAINTENANCE FORMULAS

DAYTEENS™ To help insure optiomal nutrition in growing teenagers

Each Filmtab® represents:

Vitamin A	(5000 units) 1.5 mg.
Vitamin D	(1000 units) 25 mcg.
Thiamine Mononitrate (B_1)	2 mg.
Riboflavin (B_2)	2 mg.
Nicotinamide	20 mg.
Pyridoxine Hydrochloride	0.5 mg.
Cobalamin (Vitamin B_{12})	2 mcg.
Calcium Pantothenate	5 mg.
Ascorbic Acid (C)	50 mg.
Iron (as sulfate)	10 mg.
Copper (as sulfate)	0.15 mg.
Iodine (as calcium iodate)	0.1 mg.
Manganese (as sulfate)	0.05 mg.
Magnesium (as oxide)	0.15 mg.
Calcium (as phosphate)	250 mg.
Phosphorus (as calcium phosphate)	193 mg.

In table bottles of 100, bottles of 250 & 1000

DAYALETS® Extra-potent maintenance formulas, ideal for the nutritionally "run-down"

Each Filmtab® represents:

Vitamin A	3 mg. (10,000 units)
Vitamin D	25 mcg. (1000 units)
Thiamine Mononitrate	5 mg.
Riboflavin	5 mg.
Nicotinamide	25 mg.
Pyridoxine Hydrochloride	2 mg.
Cobalamin (Vitamin B_{12})	2 mcg.
Calcium Pantothenate	5 mg.
Ascorbic Acid	100 mg.

In table bottles of 100, bottles of 50, 250 & 1000

DAYALETS-M® Each Filmtab represents all the vitamins of Dayalets plus the following:

Iron (as sulfate)	10 mg.
Copper (as sulfate)	1 mg.
Iodine (as calcium iodate)	0.15 mg.
Cobalt (as sulfate)	0.1 mg.
Manganese (as sulfate)	1 mg.
Magnesium (as oxide)	5 mg.
Zinc (as sulfate)	1.5 mg.
Molybdenum (as sodium molybdate)	0.2 mg.

In table bottles of 100 & 250, bottles of 1000

THERAPEUTIC FORMULAS

OPTILETS® Therapeutic formulas for more severe deficiencies—illness, infection, etc.

Each Filmtab® represents:

Vitamin A	7.5 mg. (25,000 units)
Vitamin D	25 mcg. (1000 units)
Thiamine Hydrochloride	10 mg.
Riboflavin	5 mg.
Nicotinamide	100 mg.
Pyridoxine Hydrochloride	5 mg.
Cobalamin (Vitamin B_{12})	6 mcg.
Calcium Pantothenate	20 mg.
Ascorbic Acid	200 mg.

In table bottles of 30 & 100, bottles of 1000

OPTILETS-M® Each Filmtab represents all the vitamins of Optilets plus the following:

Iron (as sulfate)	10 mg.
Copper (as sulfate)	1 mg.
Iodine (as calcium iodate)	0.15 mg.
Cobalt (as sulfate)	0.1 mg.
Manganese (as sulfate)	1 mg.
Magnesium (as oxide)	5 mg.
Zinc (as sulfate)	1.5 mg.
Molybdenum (as sodium molybdate)	0.2 mg.

In table bottles of 30 & 100, bottles of 1000

SUR-BEX® WITH C Therapeutic B-complex with C, for convalescence, stress, post-surgery.

Each Filmtab® represents:

Thiamine Mononitrate	6 mg.
Riboflavin	6 mg.
Nicotinamide	30 mg.
Pyridoxine Hydrochloride	2.5 mg.
Cobalamin (Vitamin B_{12})	2 mcg.
Calcium Pantothenate	10 mg.
Ascorbic Acid	150 mg.
Desiccated Liver, N.F.	150 mg.
Liver Fraction 2, N.F.	150 mg.
Brewer's Yeast Dried	150 mg.

In table bottles of 60, bottles of 100, 500 & 1000

ABBOTT

TABLE BOTTLES AT NO EXTRA COST

VITAMINS BY ABBOTT

®FILMTAB—FILM-SEALED TABLETS, ABBOTT TM—TRADEMARK

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NEWS ITEMS

J. C. Hart, M.D., has returned to Paris to resume limited practice, after spending several months in Silver Springs, Fla., where he and Mrs. Hart operated a motel. He will reopen his office on Fifth Street.

Charles L. Preston, M.D., has returned to Paintsville after three years of training at the Mid-State Baptist Hospital, Nashville, Tenn. He will practice obstetrics and gynecology, in association with **George G. Greene, M.D.** Doctor Preston was in general practice at the Paintsville Clinic for six and a half years before going to Nashville. Born in Paintsville, he received his M.D. degree from the University of Cincinnati in 1950 and interned at Walter Reed Army Medical Center, Washington, D. C. He served as a pilot in the Army Air Corps from January 1942 to August 1945, with the rank of first lieutenant.

John A. Snowden, M.D., retired physician of Winchester, has announced his candidacy for sheriff of Clark County in the May 23 Democratic primary. Doctor Snowden formerly served two terms as mayor of Winchester, during which he led in the development of the municipal housing program and the establishment of a county health unit. He also served a year as master commissioner of the Clark Circuit Court.

William Curtis Adams, M.D., formerly of the Children's Hospital, Louisville, is the new medical director of Variety Children's Hospital, Miami, Fla.

Glenn M. Shifley, M.D., has opened an office in Somerset after practicing in Asheville, N. C., since 1953. He previously practiced in Clinton, Tenn., and Covington, Ky. His specialty is anesthesiology. A native of Grays, Ky., Doctor Shifley received his medical degree from the University of Lousville School of Medicine in 1941. He interned at Louisville General Hospital and took residency training at Wesley Memorial Hospital, Chicago; Nichols General Hospital, Louisville, and Hines VA Hospital, Chicago.

William W. Winternitz, M.D., former assistant professor of physiology and medicine at the Yale University School of Medicine, has joined the staff of the University of Kentucky College of Medicine as an associate professor in the Department of Medicine. A native of New Haven, Conn., Doctor Winternitz received his medical degree from Johns Hopkins in 1945, where he also took his internship and residency training. He served two years, 1946-48, in the U.S. Army at the Army Chemical Center, with the rank of captain.

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Complete Optical Service in Kentucky—

Includes:

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Ophthalmologists'
prescriptions ONLY
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SOUTHERN OPTICAL
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FRANCIS BLDG.
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ST. MATTHEWS
313 WALLACE CENTER

Application

FOR SPACE IN THE SCIENTIFIC EXHIBIT

1961 Annual Meeting — Kentucky State Medical Association

Columbia Auditorium — **Louisville, Kentucky** — **September 19, 20 and 21**

Fill Out and Mail to:

J. THOMAS GIANNINI, M.D., Chairman

Committee on Scientific Exhibits

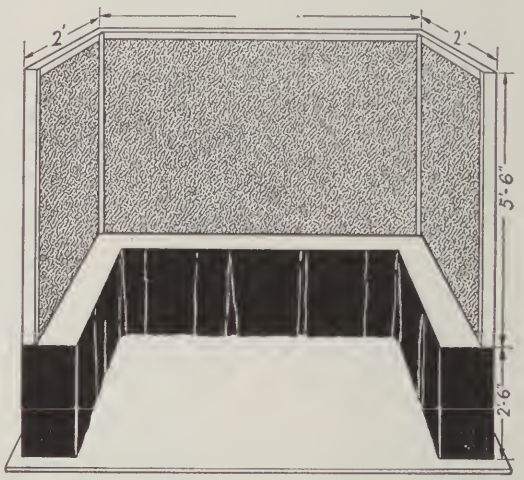
129 Medical Arts Building

1169 Eastern Parkway

Louisville 17, Kentucky

Applications for space should be received before July 1, 1961

Dimensions and structure of K.S.M.A. Scientific booth are shown in accompanying illustration



1. Title of Exhibit: .....

2. Description or nature of exhibit: (Attach brief description to this blank).

3. Will you require shelf space? .....

4. Give approximate amount of wall space needed. (Included in total space is two side walls of two feet in length) .....

5. Name of institution co-operating in the exhibit (if desired) .....

6. Name of exhibitor: .....

..... (Street & No.) ..... (City)

The Kentucky State Medical Association will provide without cost to the exhibitor the following: Exhibit space, shelves, sign for booth, current, bracket lights, provided all items are approved in advance by the committee.

Cost of transporting exhibits to the meeting must be borne by the individual exhibitor as well as costs of cards, signs, etc., which are a part of the exhibit.

View boxes, furniture, decorations, etc., may be rented, if desired, by applying directly to Jos. T. Griffin Company, 704 West Main Street, Louisville 2, who supply equipment for the annual K.S.M.A. meeting.

Student AMA

Conservative estimates of population increase in this country indicate that it will be necessary to have a 67 per cent increase in the number of medical school graduates in the next 15 years in order to maintain the current physician-population ratio. At the same time that this country is faced with the need for a substantial increase in the number of medical students, we are experiencing a steady quantitative and qualitative decrease in medical school applicants.

The major reasons offered for this decrease in medical school applicants are varied. The most common, often-voiced reason is that the medical profession has lost much of its glamor, for today many Americans see their doctor more as a technician, making his diagnosis by complicated laboratory tests and prescribing wonder drugs that the druggist counts from a big bottle, rather than the authoritarian, but friendly figure whose practice seemed to be an art with a touch of magic.

Other major reasons are economic. Most American schools require from nine to 12 or more years of training outside high school for practice in various specialities of medicine, compared to the four to six years of training necessary for many other attractive and rewarding professions. We have presently an intensive competition with the other scientific branches for superior students.

To meet this challenge, the University of Louisville Chapter of the Student American Medical Association has recently established the Medical Education Committee whose primary function is to be of assistance to high school students in acquiring information concerning a medical school education. Many medical students have expressed their desire to visit high schools for this purpose. The pilot plan for this program has already been well established, and many local city and county high schools in Louisville and Jefferson County have been visited and our program presented to the students.

Our program is being presented by a medical student of the University of Louisville and a practicing physician of the high school locality. A brief formal presentation with audio visual aids, followed by a question-and-answer session, completes the format.

Our aim is to enlarge the scope of this program so that all high school students in Kentucky may be reached. Our hope is that this program may help to reverse the present and growing trend in medical applicants. Our reward—better medical practice for the Commonwealth of Kentucky.

Herbert R. Booth, Chairman
Medical Education Committee
U. of L. Chapter SAMA

The Madison County Medical Society has gone on record as favoring a brucellosis-eradication program for the farmers of the county, according to Max E. Blue, M.D., president. Madison is one of 19 counties in the state which have not initiated the program aimed at eliminating infected cattle.



DORNWAL® HAS BEEN CALLED "THE GENERAL TRANQUILIZER FOR GENERAL PRACTICE."

Suppose the physician visiting this patient finds that he has to be hospitalized. Certainly he wants an alert but not excited fellow who can respond to the history and physical on admission. Depending on the condition, of course, the thing to do is to give the patient one or two tablets of Dornwal before he ever leaves his home.

Dornwal will calm the patient but won't make him drowsy or give him feelings of depersonalization. And what's more, while Dornwal most assuredly tranquilizes, it won't interfere with most other medications that your subsequent examination or laboratory studies may indicate.

Since every man in general practice encounters such situations almost daily, it makes good sense to keep some tablets in one's bag, doesn't it? We will be glad to send you a supply.

Dosage: One or two 200 mg. tablets three times a day. Children, age 6 to 16, one or two 100 mg. tablets two times a day. Administration limited to three months' duration.

Supplied: 200 mg. yellow scored tablets, and 100 mg. pink tablets, each in bottles of 100 and 500.

P.S. For the "Genericist", Dornwal is amphenidone

No absolute contraindications to the use of Dornwal are known. There have been no reports or evidence of habituation, addiction or drug tolerance in animal or clinical studies. Dornwal is relatively free from untoward effects when administered at recommended dosages.

Maltbie Laboratories Division,
Wallace & Tiernan Inc., Belleville 9, N. J.
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Maltbie

In Memoriam

J. W. BAILEY, M.D.
Ashland
1892-1961

John William Bailey, M.D., assistant plant physician at Armco Steel Corporation, Ashland, died January 28 at King's Daughters Hospital, Ashland, after suffering a heart attack. He was 68.

A native of Richmond, Doctor Bailey received his M.D. degree from the University of Louisville School of Medicine in 1920. He retired in 1957 as physician at Inland Steel Company's Wheelwright Division.

H. C. BEAZLEY, M.D.
Hopkinsville
1878-1961

Hugh Coleman Beazley, M.D., a Hopkinsville physician for more than 50 years, died January 29 at his home there. He was 82.

A 1901 graduate of the Medical Department of Vanderbilt University, Doctor Beazley first practiced in Bowling Green before moving to Hopkinsville. He never fully retired, maintaining an office in his home after closing his downtown office six years ago.

H. H. HOLBROOK, M.D.
Greenup
1882-1961

H. H. Holbrook, M.D., who practiced in Boyd and Greenup Counties for 40 years, died January 12 at his home in Greenup. He was 78.

A native of Lawrence County, Doctor Holbrook received his medical degree from the University of Louisville in 1910.

WILLIAM P. HUGHES, M.D.
Shelbyville

William Preston Hughes, M.D., Shelbyville physician from 1912 until his retirement about 10 years ago, died January 13 at his home in Shelbyville. He was a native of Henry County.

Doctor Hughes was graduated from the old Hospital College of Medicine in Louisville in 1903 and started practice in Christiansburg that same year.

ALBERTO RIGAU, M.D.
Harlan
1922-1961

Alberto Rigau, M.D., plastic surgeon at Harlan Memorial Hospital, was killed instantly January 21 in an automobile collision near Pineville. He was 38 years old.

Doctor Rigau was a 1949 graduate of Marquette University School of Medicine.

WILLIAM F. LAMB, M.D.
Franklin
1910-1961

William F. Lamb, M.D., a former assistant health commissioner of Kentucky, died January 25 at a hostital in Phoenix, Ariz., after a long illness. He was a former resident of Franklin, where burial took place.

Doctor Lamb received his M. D. degree from Northwestern University Medical School in 1929 and interned at Louisville General Hospital. After World War II, he was assistant commissioner with the Louisville-Jefferson County Health Department.

MILTON I. SCHWALBE, M.D.
Washington
1900-1961

Milton I. Schwalbe, M.D., former head of the urology department at Veterans Hospital, Louisville, died January 20 in Washington, D. C., where he was connected with the Veterans Administration. He was about 60 years old.

Doctor Schwalbe, who served the VA Hospital from 1946 to about two years ago, was also an associate professor of urology at the University of Louisville School of Medicine for several years.

County Society Reports

Bourbon County

The Bourbon County Medical Society has elected Marvin B. Dillon, M.D., as its 1961 president to succeed William W. Dye, M.D. Other new officers are Isadore Zapolsky, M.D., vice-president, and John C. Davenport, M.D., secretary-treasurer.

The society named Richard J. Wever, M.D., as delegate and William H. Cox, M.D., alternate delegate, to the 1961 Annual Meeting of KSMA. All are Paris physicians.

Floyd County

C. L. Allen, M.D., of Martin, was elected president of the Floyd County Medical Society at its January 13 meeting at the Lady of the Way Hospital, Martin. Other officers named were L. C. McCloud, M.D., Martin, vice-president, and Russell L. Hall, M.D., Prestonsburg, secretary-treasurer.

Doctor Hall also was chosen delegate to the 1961 Annual Meeting of KSMA and Floyd County Legislative Key Man. Doctor McCloud was picked as alternate delegate.

Johnson County

Ernest G. Skaggs, M.D., is the new president of the Johnson County Medical Society. He succeeds James W. Archer, M.D., who was named delegate to the KSMA Annual Meeting.

Paul B. Hall, M.D., was elected vice-president for 1961; Maurice M. Hall, M.D., was re-elected secretary-treasurer, and Glenn R. Powell, M.D., was chosen alternate delegate to KSMA. All are Paintsville physicians.

AAGP to Hear AMA Head, UAW Chief At Miami Beach Assembly

"Economics of Medicine—Today and Tomorrow" is announced as the subject of a panel discussion opening the annual scientific assembly of the American Academy of General Practice, April 17-20, in Miami Beach.

Featured speakers on the panel will be E. Vincent Askey, M.D., president of the American Medical Association; Walter Reuther, president of the United Auto Workers Union; Roger Fleming, director of the American Farm Bureau's Washington office; Howard Hassard, legal counsel for the National Association of Blue Shield Plans, and R. Conrad Cooper, vice-president of United States Steel. John S. DeTar, M.D., Milan, Mich., a former president of the Academy and a leader in the AMA, will be the moderator.

More than 3,500 family doctors are expected to attend the assembly. The Academy, the nation's second largest medical association, has more than 27,000 family doctor members.

U. L. Medical School Convocation Honors Retiring Librarian

The University of Louisville School of Medicine honored its retiring librarian, Miss Blake Beem, at a convocation in the Rankin Amphitheatre of Louisville General Hospital on January 31. J. Murray Kinsman, M.D., dean of the medical school, presided.

Others participating in the program were Eugene H. Conner, M.D., chairman of the Library Committee; Emmet Field Horine, M.D., emeritus professor of medicine of the U. of L. School of Medicine and official historian of KSMA, and Philip G. Davidson, Ph.D., president of the University of Louisville.

Miss Beem's retirement began February 1 after 25 years with the Louisville medical school and 40 years in medical library work.

Governor Addresses Medical Society From Capital — By Phone

What is believed to be the first telephone address from the State Capitol was delivered February 2 by Governor Combs to the Campbell-Kenton Medical Society, meeting in Covington. When bad weather prevented him from leaving Frankfort, a long-distance hookup enabled the Governor to keep his speaking engagement with the 60 physicians assembled in Oelsner's Colonial Inn.

"Good health for Kentuckians is imperative if we are to make the progress demanded of us in this space age," said the Chief Executive, emphasizing that physicians have a vital role in the development of the state. He described the new indigent medical care program as one of the most important advances in an over-all health program of the state, which also includes improvement in the areas of atomic radiation, alcoholism, tuberculosis control, immunization, the behavioral sciences and occupational health.

The Governor spoke for 15 minutes and also participated in a question-and-answer session.

Annual Meeting

Kentucky Chapter, American College of Surgeons

March 24-25 **Brown Hotel, Louisville**

Featuring

Six Outstanding Surgical Specialists

Frank Lathrop, M.D., Boston
Edward Parker, M.D., Charleston, S. C.
Milton McCall, M.D., Pittsburgh
Isidor Ravdin, M.D., Philadelphia
T. Campbell Thompson, M.D., New York
Owen Wangensteen, M.D., Minneapolis

Operative Clinics

All Physicians Invited

Symposium on Cancer

No Registration Fee

Advance Registration Necessary to Insure Attendance at Operative Clinics

Contact: William T. Rumage, M.D., Fincastle Building, Louisville

See story on Page 273 of this issue of The Journal

A REALISTIC AID TO PROPER WEIGHT MAINTENANCE

At Last...New Cook Book Designed



Free to Physicians

Menus fulfill the recommended dietary allowances of the Food & Nutrition Board of the National Research Council

o Prevent Overweight Through Better Eating Habits

Recipes and Menus that Provide Satiety and Appetite Appeal

The Cook Book of Glorious Eating for Weight Watchers fills the long-felt need for a weight control plan that is workable for everybody in the family. Realistic regimens are built around good, natural, readily-available foods enhanced by delicious methods of preparation. In place of "fad diets" or tasteless formulas, it provides for truly appetizing meals. It teaches and encourages the development of the healthful eating habits that can prevent overweight, America's #1 Health Problem. This full-color Cook Book contains 100 pages—248 delicious recipes each with calorie counts. Complete menus are here at 3 calorie levels—1200, 1800, 2600. Calorie levels are related to "best" weights by sex, age, size and extent of activity.

Many diets fail because they are "crash" programs only temporary in effect. Other diets are unbearable because they are monotonous and tasteless.

The Wesson way offers calorie controlled menus that emphasize appetite appeal, variety and satisfaction. They fulfill the recommended dietary allowances of the Food & Nutrition Board of the National Research Council.

All menus provide the proper amount of protein, carbohydrates, fat and the other essential nutrients. The principles of good nutrition are included to help the homemaker plan her own properly balanced, calorie controlled menus. With simple subtractions or additions to the same basic menu, each family member can be served delicious satisfying menus according to his individual needs.

Advance copies for physicians. "The Cook Book of Glorious Eating for Weight Watchers" has not yet been released to the general public. If you would like an advance copy for yourself, together with forms to enable patients to obtain their own *free* copies, please fill in coupon below.



Poly-unsaturated Wesson is unsurpassed by any readily available brand where a vegetable (salad) oil is medically recommended for a cholesterol depressant regimen. As an aid to physicians, Wesson has made available "Your Cholesterol Depressant Diet Book". This book is for professional distribution only—not offered *to laymen.*

Please do not confuse that offer with this one. "The Cook Book of Glorious Eating for Weight Watchers" *will be offered to the general public. It should be explained that this is not a reducing manual. Rather, it marks the first time that a major food manufacturer has taken so important a step in the interest of* prevention of obesity. *Therefore, it is expected that this new book will be highly useful to physicians in their practice.*

The Wesson People, Dept. M,
210 Baronne St., New Orleans 12, La.

Please send me my free advance copy of "The Cook Book of Glorious Eating for Weight Watchers."

Two dozen order blanks will be included for distribution to my patients who will receive free copies in return for 1 Wesson label. More blanks will be sent me if requested.

_____ M.D.

_____
(ADDRESS)

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(CITY, ZONE, STATE)

Poly-unsaturated **Wesson,** *the Pure Vegetable Oil, is Never Hydrogenated.*

Contributions Can Be A Savings To You

OLIVER WENDELL HOLMES, JR., once said, "Taxes are the price we pay for civilized society." If this be true then you might ask, "How civilized can you be?" While in this area, it might be well to look briefly at how much of our tax dollar goes to protect this civilized society. The Department of Commerce tells you to mark down your income tax. To this add 82%, which would represent the average amount of excise, corporation or other direct or indirect taxes you pay to Uncle Sam.

Take this total and then do your own arithmetic:

	Per cent of Total Tax	
Major national security	57	.....
Interest on public debt	11	.....
Veterans	6	.....
Agriculture	6	.....
Labor and Welfare	6	.....
Commerce, housing, space technology	4	.....
International	3	.....
Natural Resources	3	.....
General government	2	.....
Debt Retirement	2	.....

If your total federal taxes amount to $1,000, for example, $570 of your money is going for the Army, Navy, Marines, Air Force and other defense activities. Only $20 is going for the general expense of running the government, which most people associate with bureaucracy. The climbing national debt, which takes $110 out of each $1,000 and the infinitesimal $20 you are paying to reduce that interest should be enlightening.

Unless you are imbued with an overzealous spirit of giving to Uncle Sam, you probably are interested in keeping your outgo of tax money as low as possible. One way is to keep an eye on your contributions.

Know Your Contribution Deduction

You can deduct the donations you make to religious, charitable, educational and other allied organizations that have been approved by the Treasury Department. Normally these deductions can range from 20% to 30% of your adjusted gross income.

Some suggestions for charitable giving are:

1. Contributions paid by check are deductible in the year you give the check. For example, mailing a check you write on the last day of the year is deductible even though the charity won't receive the check until the following year.
2. You cannot deduct money your dependents put in the church basket. Even though you give them the money—you cannot claim a contribution deduction for the money they contribute.
3. Property—deductible contributions are not limited to cash donations. Donations of property (securities, houses, books, automobiles, paintings, food, goods, etc.) are deductible. The amount of your deduction is the fair market value of the donated property at the time you make the donation, not its original cost.

Tax Saving Opportunity

Giving property that has appreciated in value permits you to get a deduction for its full market value while avoiding tax on the unrealized profits (the difference between the cost basis and its fair market value). The higher your income the greater is your saving.

Say you have a security that cost $1,000 but is now worth $3,000. You can give the stock to a charity and get a deduction for $3,000. You can also give away only the appreciation on your security and get a deduction and avoid any tax on the appreciation. For example, you have a stock that cost $1,000 that is now worth $3,000. You sell the stock to a charity for $1,000. You get a deduction for $2,000 and have no income. Thus, you get your cost back, get a deduction for the appreciation, and incur no tax on this appreciation.

Also, if you or your wife do volunteer work for organizations that are classified as charitable, etc., you can deduct as charitable contributions your (1) unreimbursed commutation expenses to and from its places of operation and (2) your unreimbursed traveling expenses (including meals and lodging) on a business trip away from home for that organization. Also special uniform costs are deductible.

What Does A Contribution Cost You?

The net cost of a donation is the difference between the donation and the taxes you would have paid had you not made the donation. A few examples are shown in the table below.

If taxed income less exemptions for*	Taxes saved per dollar by taking a charitable contribution deduction is:	Leaving a net cost after tax per dollar contributed of
$ 4,000	$ .20	$ .80
8,000	.22	.78
12,000	.26	.74
16,000	.30	.70
20,000	.34	.66
24,000	.38	.62
28,000	.43	.57
36,000	.50	.50
52,000	.59	.41

*Married couples filing joint return

William E. Rudd

when you suspect
it may become more
than just a cold...



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*Council on Drugs, J.A.M.A. 165:58 (Sept. 7) 1957.

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FRENCH'S INDEX OF DIFFERENTIAL DIAGNOSIS: edited by Arthur H. Douthwaite, M.D., F.R.C.P.; published by the Williams and Wilkins Company, Baltimore; 1,111 pages; price, $24.

Ranging from accoucher's hand to weight loss, this book of 1,111 too closely packed pages is a sort of poor man's non-electronic computer.

The first part of the book is an alphabetical arrangement of symptoms and signs. Following this is a general index of diseases, signs, symptoms and laboratory findings. Whatever one can not find in this first and major portion of the volume will almost certainly be found in the general index, or second part. However, you must remember that the book is quite, quite British, so remember to look under HAEmorrhage, not hemorrhage, if you want to know something about bleeding.

I think that a lot of salutary pruning could be done and the book reduced by half, to merely fit the title "Index." As it is, I believe it tries to be too inclusive in the information it gives under many headings. However, this might impair its readability, which is of high order, and would certainly be a lifetime job.

If you happen to be in a scholarly and thumbing-through sort of mood, the book is full of fascinating bits with which to astound your friends (or enemies). For example, imaging the sheer delight of being able to say, "Ah, yes, I see this patient is exhibiting pilimiction, which almost invariably signifies a pelvic dermoid cyst discharging into the bladder." Or, "This patient is not the victim of disease. He is merely indulging in merycism which is only a habit of some high strung individuals."

All in all, this book contains a tremendous amount of information, is well written and should be of frequent help, for as has been said so often, one doesn't make a diagnosis unless one first remembers it, and who remembers everything?

Jack Chumley, M.D.

DISEASES OF THE NEWBORN: By Alexander J. Schaffer, M.D.; published by W. B. Saunders, Philadelphia and London, 1960; 878 pages, price, $20.

Diseases of the Newborn is a well-written reference for the practitioner of newborn pediatrics, whether he be medical student, general practitioner, pediatrician or obstetrician. Diagnosis and therapy are stressed; theoretical considerations are kept to a minimum.

Dr. Milton Markowitz is the only other contributor to the volume, with his section on neonatal cardiology. Doctor Schaffer explains that he does not consider himself the best authority in all topics covered. Yet, this book is written for the man who is seeing the newborn, not for the subspecialist who may be called later.

The book is divided into 15 sections and 114 chapters. Clear photographs, tablets and charts are profuse and pertinent. Four of the sections have chapters on differential diagnosis. These are excellent in their detail, and do not resort to a mere listing of possibilities.

Many topics are accompanied by illustrative cases which include a summary comment for added clarity. Many topics prove to be gems of satisfaction in their completeness; there are three pages devoted to the subject of "excessive crying."

The weakest section appears to be that on infectious diseases. While most diseases are sufficiently covered, some are passed with considerable brevity. The comments on typhoid fever are of little value.

The four appendices are a treasure unto themselves. They provide plans of management for infant nursery care, for resuscitation, and for erythroblastosis. Last, there is a pharmacopea for the newborn period.

The book is a valuable addition to our library.

J. Kenneth Harris, M.D.

RUDOLPH MATAS: by Isidore Cohn, M.D., with Hermann B. Deutsch; published by Doubleday & Company, Inc., Garden City, N. Y.; 431 pages; price, $5.95.

A well written biography by one who knew and obviously loved Dr. Matas. It is written in such a manner that it can be read, understood and enjoyed by the lay public as well as by the members of the medical and allied professions.

The book starts with a short but graphic account of the ancestors on both the mother's and father's side of the house. This begins in the late 16th Century in Spain. The biography ends at Dr. Rudolph Matas' death in the mid 20th Century. At his death, Dr. Matas was ten days short of being 97 years old.

Dr. Matas' childhood was somewhat unhappy in that his mother and father did not agree and they lived apart from the time of his early teens. It is all the more remarkable that the son became such a hard and relentless worker, ever striving for more and more knowledge.

He lived in the beginning of the advancement of medicine from the doldrums of the dark ages. His contributions in the advancement of surgery are well known, but in this biography his contributions to the field of general medicine are brought to light. Having had yellow fever as a child and thereby immune, he could and did long and timely work in the various

(Continued on Page 300)

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References: 1. David, N. A.; Porter, G. A., and Gray, R. H.: Monographs on Therapy 5:60 (Feb.) 1960. 2. Ford, R. V.: Current Therap. Res. 2:92 (Mar.) 1960.

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IN THE BOOKS

(Continued from Page 298)

yellow fever epidemics. He also was one of the early workers in the effort to discover the cause and prevention of yellow fever.

Too much time is spent describing the friendship between Dr. Matas and Lafcadio Hearne. They were great friends in their younger years but there is no evidence in this biography that Mr. Hearne influenced Dr. Matas in his study and work. The considerable space given to this association might have better been given to letting us know more of the teaching activities in which Dr. Matas excelled.

Eugene Tood, Jr., M.D.

YOUR CHILD'S CARE: by Harry R. Litchfield, M.D., F.A.C.P. and Leon H. Dembo, M.D.; published by Doubleday & Company, Inc., Garden City, N. Y., 1960; 257 pages; price, $3.95.

This is a revised and enlarged, second edition of "Pediatric Manual For Mothers." It is designed as a quick-reference handbook based on what the authors purport to be the most common queries put to them in 40 years of pediatric practice.

Using the question and answer type of format, Drs. Litchfield and Dembo have found a convenient method of dispensing much basic information. The type and scope of the questions asked are such that a comprehensive range of pediatric subjects is covered; however, the answers are simple, clear and concise, thus avoiding lengthy technical explanations which would defeat the 'ready-reference' intent of the book. Admittedly, the answers will not satisfy some of the more well informed and curious parents but should prompt them to make further inquiries of their doctor. For, as the authors emphasize, their aim is neither to alarm unnecessarily by the array of symptoms cited nor to supplant the doctor, but to anticipate and answer some of the questions asked by anxious mothers and to impress the importance of consulting a physician and not trying to self-diagnose.

As with other similar books, basic topics such as the newborn baby, formula preparation, feeding, immunization, features of growth and development, common childhood diseases, and behavior problems are adequately covered. In addition, some of the more recent advances in pediatrics—Salk vaccine, fluorine prophylaxis of teeth, newer drugs, new techniques in surgical treatment of congenital heart disease—are noted.

Disorders which have received much publicity by the lay press—nephrosis, muscular dystrophy, cystic fibrosis, tuberculosis, and epilepsy—are discussed. Chapter on Cancer in Childhood, the Diabetic Child, Diseases Transmitted by Birds and Animals, and Poisons are included.

Parents probably will find the section dealing with the selection of toys and books, music, movies, radio, television, nursery school, camp, and baby sitters especially interesting and helpful.

D. Geraldine Paxton, M.D.

Special travel schedules have been arranged in connection with the 15th General Assembly of the World Medical Association in Rio De Janeiro, Brazil, September 15-20. For air travelers, there is a basic 12-day tour including Rio, Brasilia and Sao Paulo at $780 per person; add Montevideo, Santiago and Buenos Aires for a 21-day journey at $978, or include stops in Lima, Panama and Columbia for a 30-day trip at $1,437. All these tours leave New York on September 13. A 38-day medical study cruise on the S. S. Brazil leaves August 25 and returns October 3. Its cost is $1,700. For further information, write: Louis H. Bauer, M.D., secretary-treasurer, the World Medical Association, United States Committee, Inc., 10 Columbus Circle, New York 19, N. Y.

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From the files of the COMMITTEE FOR THE STUDY OF MATERNAL MORTALITY



CASE No. 75—a 23 year old married white primigravida whose last menstrual period had begun on May 20, 1960, was first seen by her private physician on July 14, 1959.

Month of Pregnancy

1	2		3	4		5 6 7 8 9
	1	2		1	2	
Date	7/14	7/21	8/24	9/4	9/11	
Blood Pressure	112/70	114/76	110/60	110/60	116/76	
Weight	116	117	114	112	115	
Albuminuria	Neg.		Neg.		Neg.	
VDRL	Non-reactive					
Rh Factor	Negative					

The patient had been treated from 12/11/57 to 12/20/57 and from 12/27/57 to 1/2/58 for cystitis and pyelitis with sulfa and chloromycetin. An intravenous pyelogram demonstrated a slightly dilated, blunted superior calyx which the radiologist interpreted as showing inflammatory changes. She had had irregular periods in 1959, and was amenorrheic in March. A pregnancy test in April was negative, and shortly thereafter she had a normal period. On April 4, her hemoglobin was 14.4 grams, red blood count 4,662,000; WBC 13,000 with 87 polymorphonuclear leukocytes and 11 lymphocytes. Physical examination on July 14, 1959, showed the uterus to be approximately twice normal size and slightly tender.

On July 21, the patient consulted her physician because of slight vaginal spotting and some pain in her legs and lower back. The doctor made a diagnosis of endocervicitis, and treated this by application of silver nitrate. Meprobamate was prescribed for discomfort.

At a return visit on August 24, the patient complained of bleeding gums and soreness of the mouth and tongue of one week's duration. The blood pressure was 110/60. Examination showed evidence of ulcerative stomatitis, glossitis, gingivitis, and focal capillary alveolar hemorrhage. The working diagnosis was that of gingivitis and stomatitis of pregnancy, and the treatment consisted of antiseptic mouth wash and ascorbic acid. On September 4, the stomatitis was still present; a two per cent aqueous gentian violet solution was applied locally, and antibiotic therapy with Pan Alba was prescribed.

On September 11, the patient collapsed, apparently because of extreme weakness. There was no improvement in the stomatitis. A blood count done at the hospital showed a hemoglobin of 8.6 grams; RBC 2,220,000; marked lymphocytosis; and a platelet count of 32,000 mm. On the following day, she was hospitalized; a transfusion of two pints of B positive blood was administered on September 14.

Following the transfusion, the bleeding time was 3½ minutes, clotting time 8 minutes by the capillary method, and no clot retraction was observed in two hours. She was given an additional two pints of blood and started on Medrol therapy. On September 16 the hemoglobin was 10.8 grams; RBC 3,330,000; WBC 1,100; with 40 polymorphonuclear leukocytes, 60 lymphocytes, 28,000 platelets per cubic millimeter. The urinalysis was reported as showing a specific gravity of 1,010 and a pH of 5. Microscopically the specimen was loaded with squamous epithelial cells; no erythrocytes were noted.

On September 18, a bone marrow aspiration showed aplastic changes. She was given another pint of whole blood. On September 29, the hemoglobin was 9.6 grams; RBC 2,886,000; WBC 2,450 with 2% eosinophils, 82% polymorphonuclear leukocytes, 3 lymphocytes and 40,000 platelets.

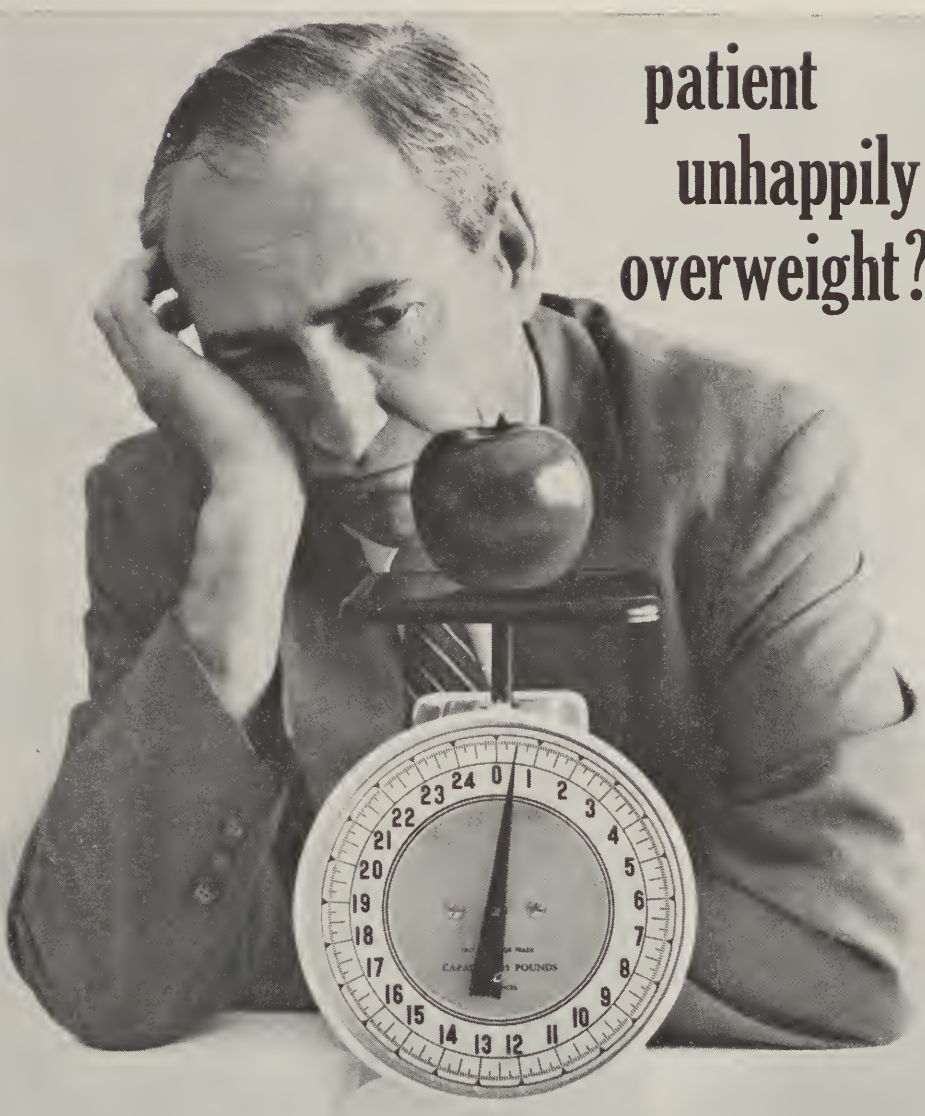
Because of progressive weakness and continued hemorrhage from the alveolar margins, the patient was readmitted on October 11. Two days before readmission, the hemoglobin was 8 grams, WBC 1,600 with 12 polymorphonuclear leukocytes; 82 lymphocytes and 6 monocytes. The platelet count was 32,000. Another transfusion was administered.

During the ensuing two weeks, six more transfusions were necessary, and the laboratory signs of aplastic anemia persisted.

On October 28, the patient went into labor spontaneously, and progressed to full cervical dilation in two hours. The membranes then ruptured spontaneously. After thirty minutes of second stage labor, a stillborn fetus weighing four ounces was spontaneously extruded. One hour later, manual removal of the retained placenta was carried out under general anesthesia, and a uterine pack was inserted. The patient died five and one half hours after delivery.

An autopsy was performed. The gross pathological diagnoses were (1) aspiration pneumonia, (2) bilateral pulmonary atelectasis, and (3) aplastic anemia with terminal thrombocytopenic purpura. The microscopic findings included (1) severe panhypoplasia of bone marrow (aplastic anemia); (2) terminal aspiration pneumonia; (3) marked phagocytosis of hemosiderin in sections of lung; (4) pulmonary atelectasis

(Continued on Page 304)



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[1] Douglas, H. S.: West. J. Surg. 59:238 (May) 1951.

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MATERNAL MORTALITY PAGE

(Continued from Page 302)

and edema; (5) marked congestion of the spleen; and (6) terminal thrombocytopenic purpura. On the death certificate, the cause of death was stated to be aplastic anemia.

Comments

The Committee interpreted the data in this protocol to indicate that the patient died from a rare type of primary aplastic anemia which was refractory to all therapeutic measures. Since a normal blood count was recorded on April 4, 1959, the anemia was demonstrably of recent origin.

Pregnancy complicated by refractory anemia is rare. Rovinsky, in 1959, found only 42 such cases in the literature, and only 16 of these were unequivocally primary.

The clinical criteria are those of persistent, severe anemia with granulocytopenia and thrombocytopenia refractory to all treatment other than whole blood transfusion. Secondary anemias associated with infection, chronic renal or hepatic disease, malignant neoplasia or drug ingestion must be ruled out.

The maternal hazards in this complication of pregnancy are anemia, infection and hemorrhage; the refractory and progressive anemia is the cause of death. The possibility of incompatible transfusion reaction may be reduced by the use of correctly cross-matched packed erythrocytes from which the layer containing the leukocytes and the platelets has been removed. The associated severe leukemia makes infection a constant threat. This danger may be somewhat reduced by the prophylactic administration of broad spectrum antibiotics.

Former KSMA Secretary Is Author Of Book On Teen-Age Boy

"The Teen-Age Boy—What Makes Him Tick?" is the title of a new book authored by Mrs. Isabel Cummings, Louisville, a former secretary in the KSMA Headquarters Office.

The 234-page book is composed of 26 essays dealing with problems which sooner or later will be faced by teen-age boys. Published by Books, Inc., of New York City, it sells for $1.

Mrs. Cummings, the mother of a teen-age son and daughter, is working on a second book, this one dealing with the teen-age girl.

Louisville to Have Medical Towers

Medical Towers, an eight-story medical-offices building, is soon to rise in Louisville's Medical Center. The glass and aluminum structure, estimated to cost well over $1,000,000, will be located at the northwest corner of Floyd and Gray Streets.

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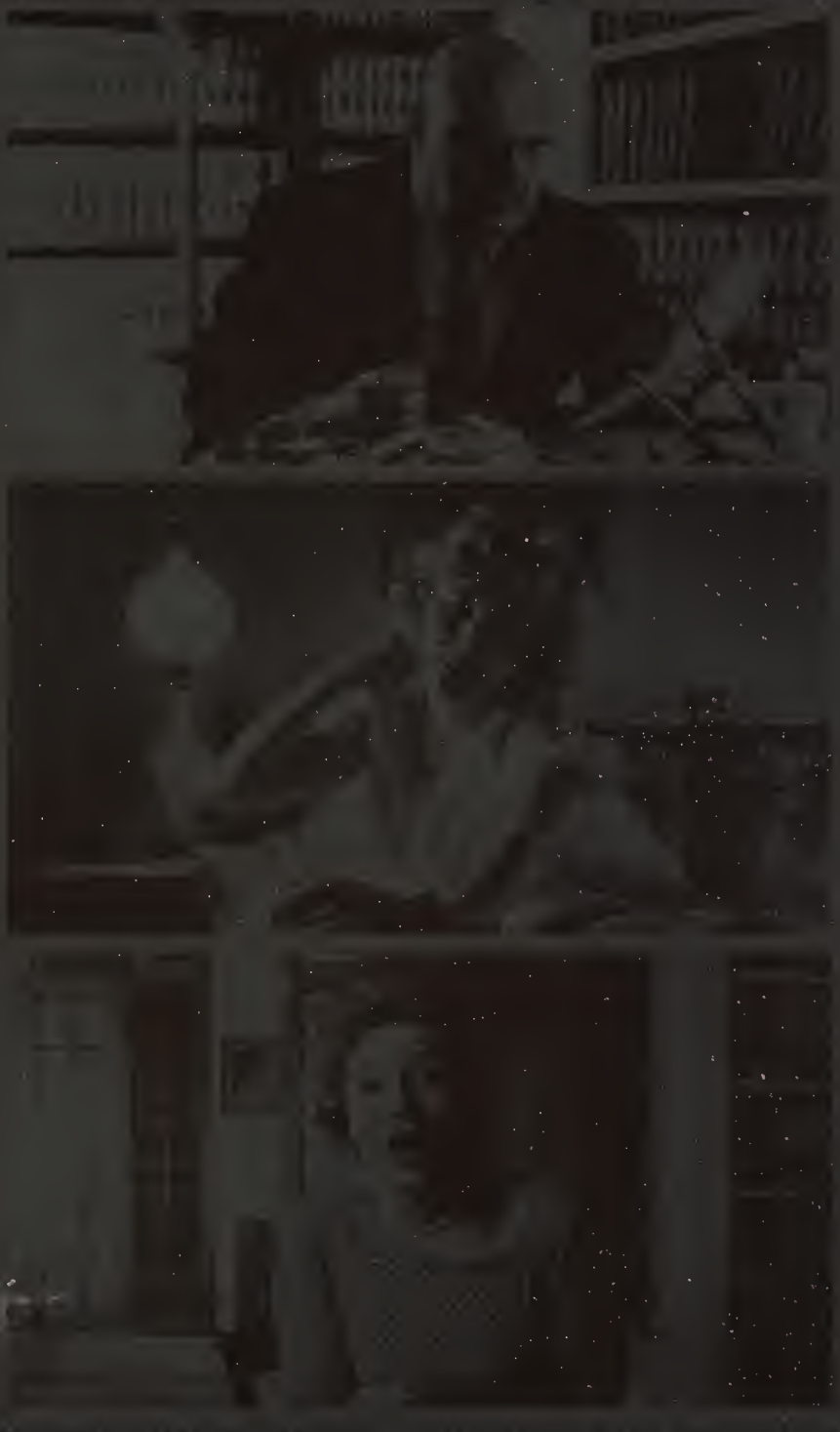
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Hollander[1] points out the superiority of triamcinolone in not causing mental stimulation, increased appetite and weight gain, compared to other steroids which produce these effects in varying degrees. And McGavack,[2] in a comparative tabulation of steroid side effects, indicates that triamcinolone does not produce the increased appetite, insomnia, and psychic disturbances associated with other newer steroids.

ARISTOCORT can thus be advantageous for patients requiring corticosteroids whose appetites should not be stimulated, and for those who are already overweight or should not gain weight. Likewise, ARISTOCORT is suitable for the many patients with emotional and nervous disorders who should not be subjected to psychic stimulation. Furthermore, ARISTOCORT Triamcinolone, in effective doses, showed a low incidence of side reactions and is a steroid of choice for treating the older patient in whom salt and water retention may cause serious damage.[2]

References: 1. Hollander, J. L.: *J.A.M.A.* 172:306 (Jan. 23) 1960. 2. McGavack, T. H.: *Nebraska M. J.* 44:377 (Aug.) 1959. 3. McGavack, T. H.; Kao, K. Y. T.; Leake, D. A.; Bauer, H. G., and Berger, H. E.: *Am. J. M. Sc.* 236:720 (Dec.) 1958.

Precautions: Collateral hormonal effects generally associated with corticosteroids may be induced. These include Cushingoid manifestations and muscle weakness. However, sodium and potassium retention, edema, weight gain, psychic aberration and hypertension are exceedingly rare. Dosage should be individualized and kept at the lowest level needed to control symptoms. It should not exceed 36 mg. daily without potassium supplementation. Drug should not be withdrawn abruptly. Contraindicated in herpes simplex and chicken pox.

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PUBLIC HEALTH PAGE

Narcotic Addiction

RUSSELL E. TEAGUE, M.D., M.P.H.
Commissioner of Health
Commonwealth of Kentucky

SEVERAL years ago the American Medical Association and the American Bar Association appointed a joint committee to study the problem of narcotic drug addiction. The joint committee submitted a recommendation favoring the development of ambulatory treatment clinics for narcotic addicts in the community rather than in institutions. Final action on the recommendation is still pending.

Past experience in the treatment of narcotic addiction has shown that ambulatory treatment clinics are unsuccessful, impractical and unsound, and that addiction actually increases as a result of such clinics.

During 1919, seventy-five or more narcotic clinics were opened by state and municipal health departments in cities throughout the United States as an experiment to find a simple solution to the many problems due to narcotic addiction. These clinics proved to be merely supply stations for addicts. Instead of reducing the addict population, the experiment increased it.

In New York State alone, where sixteen or more narcotic clinics were in operation, almost 4,000 ounces of narcotic drugs were seized in illicit channels during one year. This was almost as much as was seized in the entire United States in 1952. In 1923, these experimental clinics were closed. In my opinion they were complete failures.

Voluntary patients account for two-thirds of the admissions to federal narcotic hospitals. Only 25 per cent of these remain for the recommended minimum period of 4½ months. Of the 75 per cent who do not stay for the minimum period of treatment, 50 per cent leave in less than 30 days. Only the one-third admitted under court orders are required to remain the full time prescribed by the hospital staffs.

After years of experience, the State Board of Health has come to the conclusion that the only adequate and successful treatment of narcotic addiction requires constant control in a secure institution affording a drug-free environment.

Due to the possibility that proponents of the ambulatory treatment clinic plan might sponsor legislation legalizing such treatment for narcotic addicts, the State Board of Health recently adopted a resolution which provides:

1. That the State Board of Health of Kentucky opposes the development of ambulatory treatment clinics for narcotic addicts.
2. That the State Board of Health does not oppose, however, after the complete withdrawal of the addict, follow-up treatment at rehabilitation centers.
3. That the State Board of Health supports the advancement of:
   (1) Measures designed to require the compulsory commitment of drug addicts for treatment in a drug-free institution;
   (2) Methods and measures designed towards rehabilitation of the addict;
   (3) Methods for the dissemination of factual information on narcotic addicts to the members of the medical profession.

For many years the State Board of Health, through its Division of Investigation and Narcotic Control, has conducted a rehabilitation program for addicted physicians. Under this program, the addicted physician is placed on probation in an administrative proceeding before the Board. His narcotic license is surrendered and he takes such treatment as the Board deems necessary. After such treatment, he is permitted to participate in some type of closely supervised practice, and his progress is evaluated periodically. After the physician successfully completes a two-year probation, his license is reinstated by the Board.

The Board's program for the rehabilitation of addicted physicians has been commended nationally.

The U. S. Bureau of Narcotics is very concerned over the support recently given favoring the development of ambulatory treatment clinics and has requested the various state medical societies to adopt resolutions opposing such clinics. At least five state medical societies have already taken such action. This matter will soon come before KSMA.



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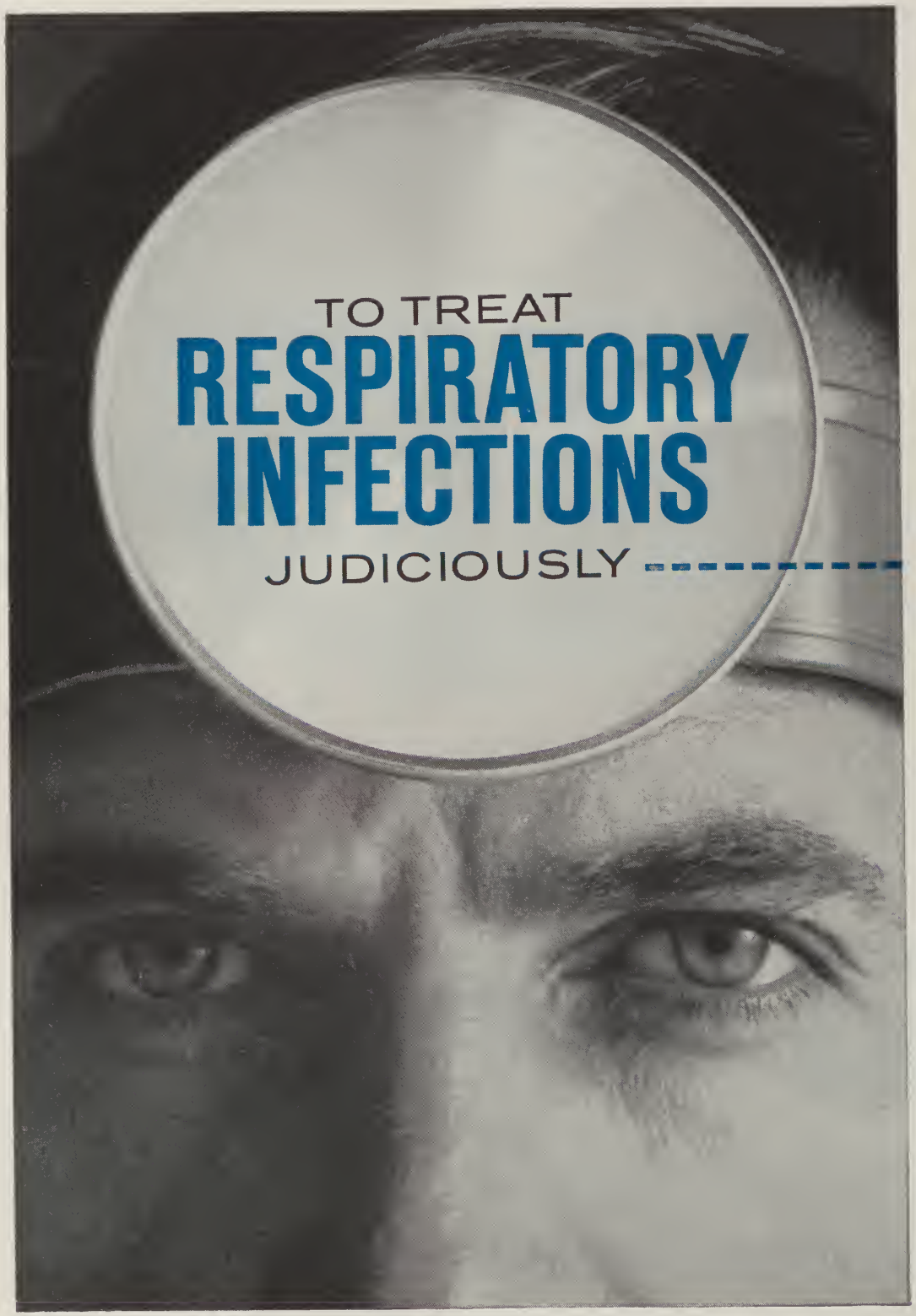
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(Continued from Page 265)

by training and education, are physicians and surgeons. It is a highly organized profession and has the same pride and confidence in its national, state and affiliated educational and professional organizations as the medical profession has in its organizations.

The Florida Osteopathic Medical Association stresses the importance of both professions helping their members to develop objective views toward the other profession, and of making of primary importance the welfare of the patients. It was estimated in 1952 that doctors of osteopathy were providing complete health care to some 9,000,000 Americans, and the number has undoubtedly increased since that time. It is this group of Americans who are affected by unsatisfactory relationships between the medical and osteopathic professions.

References

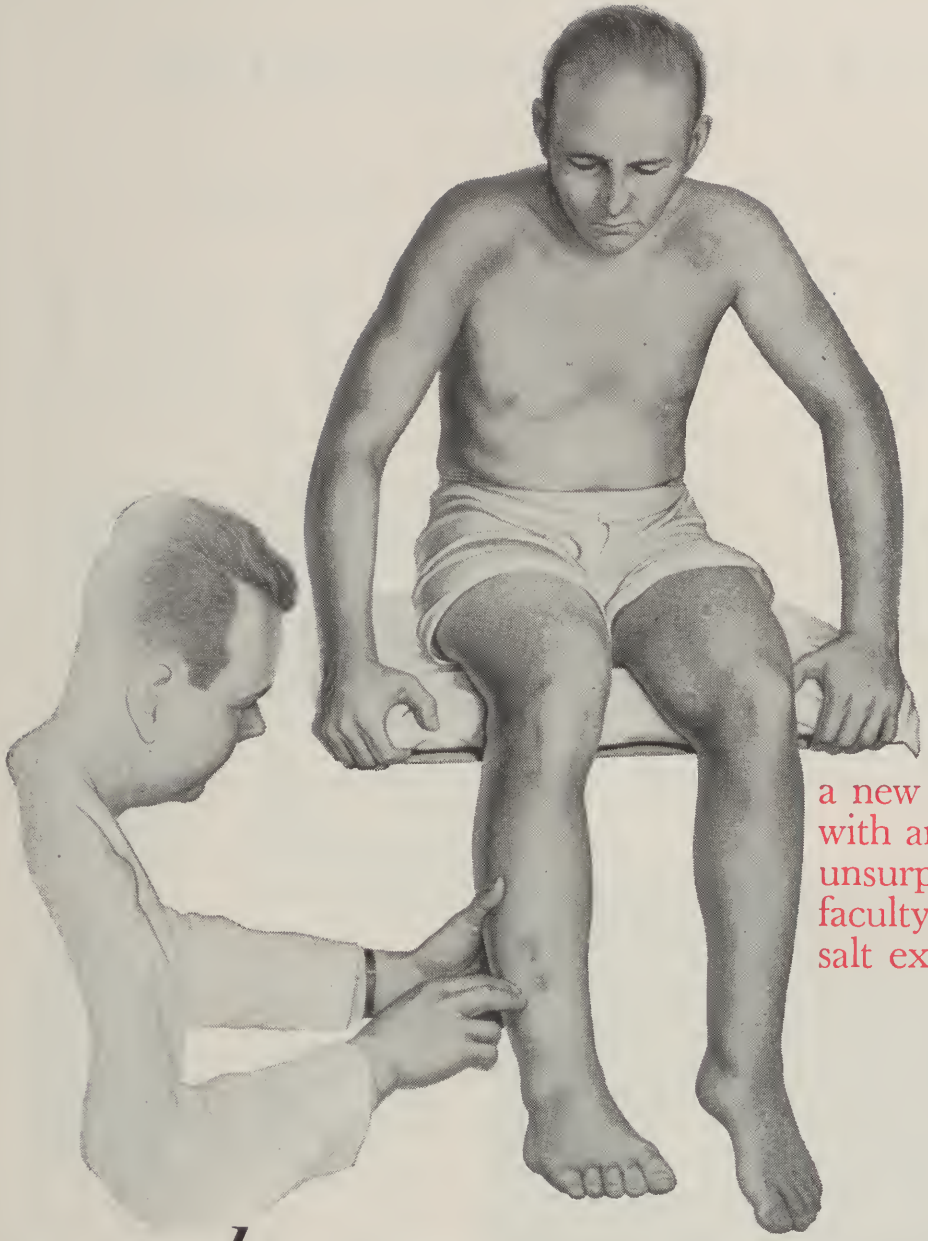
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W. Virginia AOO Meet April 6-8

Nine scientific presentations are scheduled on the program announced for the 14th annual meeting of the West Virginia Academy of Ophthalmology and Otolaryngology, April 6-8, at the Greenbrier Hotel, White Sulphur Springs, W. Va. A non-member registration fee of $25 will cover all the social and scientific sessions and entitle graduate doctors of medicine to associate membership in the academy, according to Worthy W. McKinney, M.D., secretary-treasurer. For further information, write Doctor McKinney, 109 East Main Street, Beckley, W. Va.

EET Congress At Roanoke April 3-8

The 34th annual Spring Congress of the Gill Memorial Eye, Ear and Throat Hospital of Roanoke, Va., will be held April 3-8 at Roanoke, it is announced by J. K. Hutcherson, M.D., Louisville, director for Kentucky.



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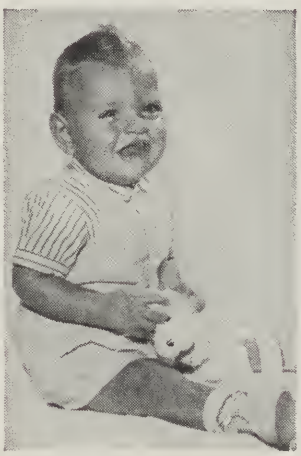
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*MC GOVERN, J. P., MC ELHENNEY, T. R., HALL, T. R., AND BURDON, K.D.: ANNALS OF ALLERGY 17:915, 1959.

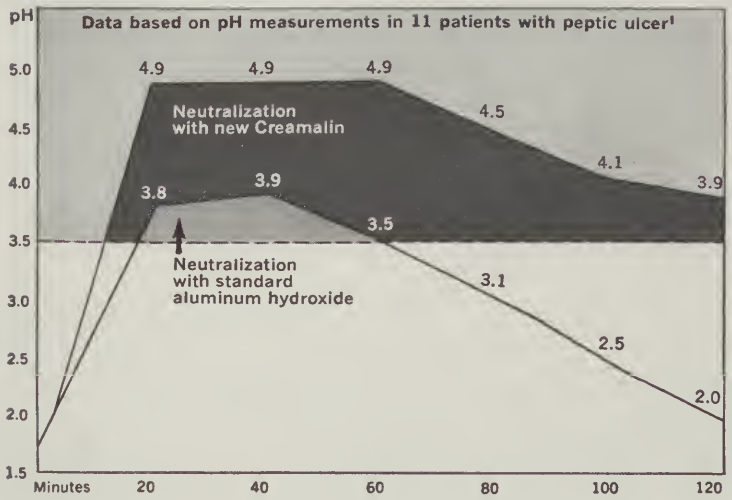
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1. Weissberg, G.: Clin. Med., June 1960.

2. Spoor, H. J.: N. Y. St. J. Med., Oct. 15, 1958.

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*Pomeranze, J.: J. New York M. Coll. *1*:32, 1959.

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Re: *New* Nonsteroid Chemotherapy of RHEUMATOID ARTHRITIS

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The "ideal" drug for rheumatoid arthritis would be "...one that is effective in the majority of those afflicted, and of such low toxicity that it can be given, in an effective dosage, for as many years as may be necessary to control the disease process in any given patient."[1]

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1. Bagnall, A. W.: Antimalarial compounds in rheumatoid disease, *Canad. M.A.J.* 82:1167, June 4, 1960.

2. Carnbleet, Theadare: Discoid lupus erythematosus treated with Plaquenil, *A.M.A. Arch. Dermat.* 73:572, June, 1956.

*Planalar, trademark

Plaquenil (brand of hydroxychloroquine), trademark reg. U.S. Pat. Off.

President's Page*



Dr. Lyon
Vice-President—Eastern

A Bear By the Tail

AT no previous time has medical care and health management been placed so conspicuously in the public consideration. The many facets of this problem are of increasing concern to all segments of our people. We have seen this mushroom cloud pervade the bargaining table, local civic enterprise, state administrative function and, quite recently, the presidential election. In terms of scientific analysis it might be well to analyze its etiology, current status and prognosis.

We of organized medicine—I use the term with reservation—have figuratively got a "bear by the tail." Actually, we have allowed a third party to be inserted in doctor-patient relationship. This was done with good intention, aimed at budgeting the cost of medical care in terms of health insurance, increasing research in the field of experimental medicine and providing greater efficiency in the areas of public health and preventive medicine.

This "bear," however, soon grew to such proportion that we, the purveyors of health care, now have a choice of hanging on and risking the consequence or of turning loose and being devoured, or at least maimed, by this creation of our own doing.

It might be well at this time to state that this creation was conceived at a time when welfare concepts of the people as well as the government accepted this idea wholeheartedly, and its promulgation was not difficult. It was even accelerated by those who rally around the banner of change. Bureaus begat bureaus, commissions of pseudo-official alignment soon burgeoned into auspicious stature.

Currently, we find that to resist in any form is criticized by many. To condone accumulates equal wrath from others, and to do nothing is scorned by all. How, then, does one manage to extricate one's self from this unenviable position of having a "bear by the tail?"

Prognostically, we must say that it will get worse before it gets better. We must bolster ourselves with the belief that what we do is right. There must be collective soul-searching and critical self-analysis that will take the best in all of us. There will be scorn, derision, even abuse as there is evolved a philosophy that is activated in deeds, but let us pray that principle can be the goal, and not expediency which is the name of our "bear."

Wendell V. Lyon, M. D.
Vice-President—Eastern

This is the third of a series of four guest articles written at the invitation of Richard G. Elliott, M. D., KSMA president.

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Advertising medical products on TV—great epidemics of the past—leading foreign medical journals—schedule of 1961 conventions—officials and executive staff of the AMA—average income of doctors in U.S.—tuberculosis and death rate—narcotics regulations—license renewal by state—federal legislation affecting doctors.

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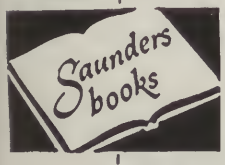
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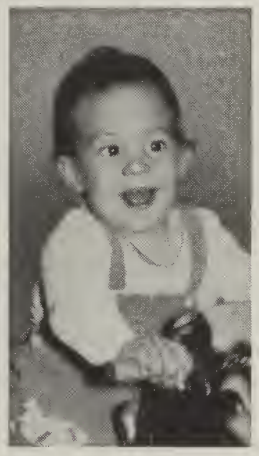
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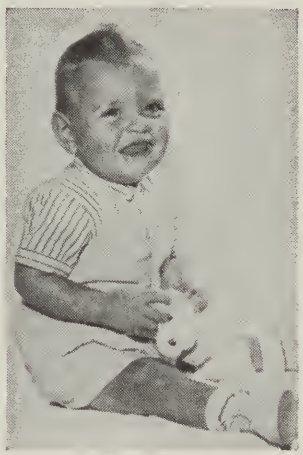
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THE INSURANCE PAGE



Blue Shield Continues To Grow And To Serve

THE president of the board of directors of Kentucky Physicians Mutual, John Dickinson, M. D., has just released the figures for the operation of the Plan for the year 1960.

Every Kentucky physician can take pride in the effective work our Blue Shield Plan is doing to help our people provide the proper health care for themselves on a voluntary basis:

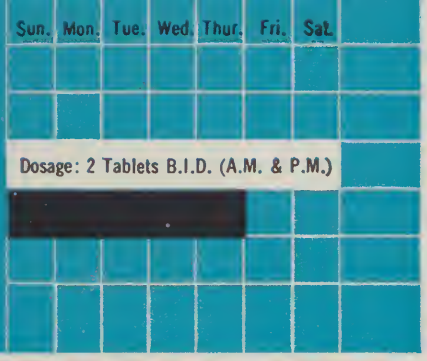
1. In 1960, Kentucky Physicians Mutual paid $6,125,485.36 to doctors for their services. This represented an increase of more than a million dollars over the amount paid in 1959.
2. Of this amount, 48.29% was for surgery done in hospitals.
3. The remaining 51.71% was for office or home surgery, obstetrical services, in-hospital medical, X-ray, anesthesia and radium therapy.
4. New members enrolled in 1960 totaled 141,282, bringing the membership to 702,028 at the end of the year.
5. Over 6,500 firms in Kentucky now offer protection to employees on a group basis.
6. A total of 188,774 claims was paid in 1960, as compared to 164,849 the previous year.

Obviously, as our Blue Shield Plan increases its coverage and services, there will be many problems of mutual interest between the Plan and its participating physicians. The staff of Kentucky Physicians Mutual has requested that through this Insurance Page they again be allowed to inform all county medical societies that members of Blue Cross-Blue Shield Hospitals and Physicians Service Department are available to meet with societies in regular or called sessions to discuss these problems and to answer questions about Blue Shield or Blue Cross.

There have been many such meetings with county societies in the past. Any society which desires to arrange for such a representative to meet with it should write to: Blue Cross-Blue Shield, 3101 Bardstown Road, Louisville 5, Ky.

In March of this year, a letter was written to the presidents and secretaries of all county medical societies by the president of Kentucky Physicians Mutual, Dr. Dickinson, with a card enclosed for arranging to have a representative of the Blue Shield staff attend a society meeting. It is hoped that all of our societies will avail themselves of this service.

W. Vinson Pierce, M. D.



in premenstrual tension only neo Bromth® treats the whole syndrome





It was the introduction of neo Bromth several years ago that created such widespread interest in the premenstrual syndrome—because of neo Bromth's specific ability to prevent the development of the condition in the first place.

The action of neo Bromth is not limited merely to control of abnormal water retention, or of nervousness, or of pain—or any other single or several of the multiple manifestations characteristic of premenstrual tension. neo Bromth effectively controls the *whole* syndrome.

neo Bromth is also completely free from the undesirable side effects associated with such limited-action therapy as ammonium chloride, hormones, tranquilizers and potent diuretics. neo Bromth has continued to prove to be the safest—as well as the most effective—treatment for premenstrual tension.

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in peritonitis

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Adult dosage: 2 capsules four times a day.

Side effects: Panmycin Phosphate has a very low order of toxicity comparable to that of the other tetracyclines and is well tolerated clinically. Side reactions to therapeutic use in patients are infrequent and consist principally of mild nausea and abdominal cramps.

Albamycin also has a relatively low order of toxicity. In a certain few patients, a yellow pigment has been found in the plasma. This pigment, apparently a metabolic by-product of the drug, is not necessarily associated with abnormal liver function tests.

Urticaria and maculopapular dermatitis, a few cases of leukopenia, and agranulocytosis have been reported in patients treated with Albamycin. All of these side effects rapidly disappeared upon discontinuance of the drug.

Caution: Since the use of any antibiotic may result in overgrowth of nonsusceptible organisms, constant observation of the patient is essential. If new infections appear during therapy, appropriate measures should be taken.

As with any serious infection, therapy of peritonitis with Panalba or other antibacterial agents is adjunctive to surgical procedures and supportive therapy.

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WASHINGTON NEWS DIGEST

Washington, D. C.—The medical profession, the U. S. Public Health Service and the National Foundation are working together in an all-out drive to get as many persons as possible to take Salk vaccine shots before the summer polio season starts.

The Sabin live polio vaccine will not be available in quantity this year.

The Salk vaccine campaign drive is directed particularly at children and younger adults in the lower economic groups.

Julian P. Price, M.D., Florence, S. C., chairman of the American Medical Association's Board of Trustees, pointed out that many children and younger adults in the lower income groups have not been inoculated against polio.

"As long as 'islands of unvaccinated persons' exist even within well-vaccinated communities, polio epidemics remain a serious threat," Doctor Price said.

Luther L. Terry, M.D., Surgeon General of the Public Health Service, emphasized the need for immunizing infants. He also said that the PHS will encourage behavioral studies to determine reasons why some people refuse to take polio shots. It is hoped that then methods may be devised to overcome such refusal.

Doctor Terry called particular attention to the findings of the PHS's Advisory Committee on Poliomyelitis Control that the recommended dosage schedules may be modified to permit the administration of three shots of Salk vaccine before summer to persons who have not had any vaccine before.

Doctor Price stressed that success of the "babies and breadwinners" polio vaccine campaign depends on joint activity at the local level by medical societies, boards of health and voluntary health agencies. He expressed confidence that the more than 2,000 state and country medical societies throughout the country would cooperate wholeheartedly.

"Contrary to recent reports (in Scripps-Howard newspapers)," Doctor Price said, "the AMA is strongly behind every effort to encourage the public to take advantage of the Salk vaccine without delay."

The Advisory Committee urged that "immediate steps . . . be taken by all interested groups to intensify drives for vaccination with the formalin-inactiviated (Salk) vaccine." The Committee also endorsed the plan to direct the campaign particularly at the lower socioeconomic and younger age groups.

The Committee recommended that the first available supplies of the Sabin live, oral vaccine be utilized in the following priority order:

1. Epidemic control, investigations and community studies.
2. Immunization of infants and pre-school children.
3. Selected area immunization of those segments of the population that are least well immunized.

•

CONGRESS NOW HAS before it legislation to carry out all of President Kennedy's broad health program, but it is doubtful that the lawmakers will act upon some of it this year.

Kennedy health legislation sent to Congress recently included bills on medical education and federal grants for nursing homes and other community facilities.

The Chief Executive also recommended an expanded program to combat water pollution. He requested Congress to authorize federal grants of $125 million a year for 10 years to help states forming interstate water pollution control agencies. He also recommended increased federal aid to communities building sewage treatment plants.

The President proposed creation of a special unit in the Public Health Service to handle both air and water pollution matters.

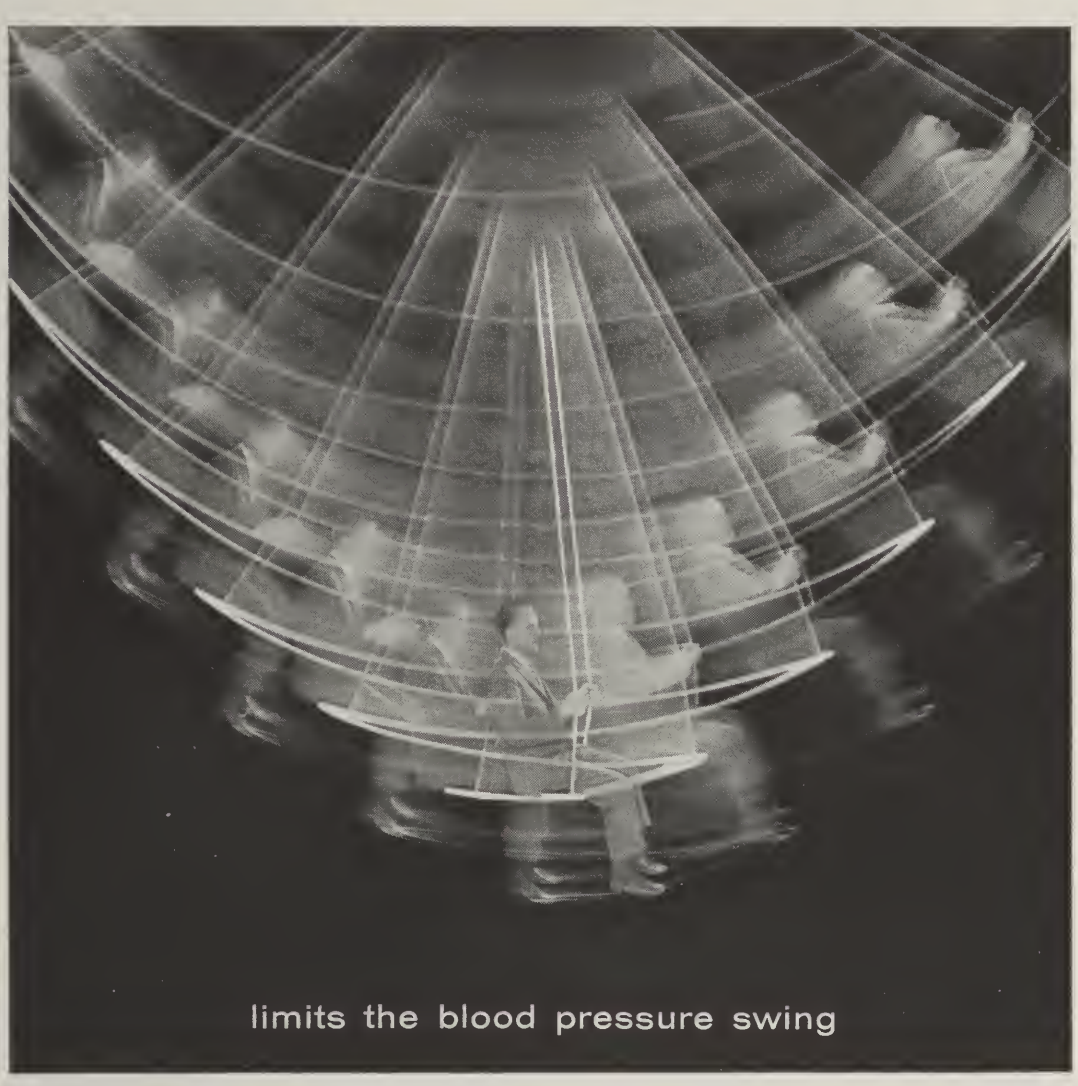
In accompanying letters to the presiding officers of the House and the Senate, Kennedy said he regarded his medical education proposals as the keystone of the over-all health program because "we are not presently training enough (physicians) to keep up with our growing population."

The other bill would "make possible a substantial addition to the number of nursing home facilities to care for long-term patients, and . . . help relieve the shortages of home health care programs," Kennedy said.

The medical education measure would authorize federal grants for scholarships for medical and dental students. Each medical and dental school would be eligible for a total of scholarship grants equal to $1,500 times one-fourth of the enrollment after the program had been in effect for four years. The maximum individual scholarship would be $2,000 a year. Participating schools also would be eligible for federal grants of $1,000 per scholarship to help pay a school's operating expenses.

The community health facilities bill would increase the annual authorization for federal grants for construction of nonprofit nursing homes from $10 million to $20 million and raise the minimum state allotment from $50,000 to $100,000 per year. It also would broaden the PHS Surgeon General's authority to conduct research, experiments and demonstrations on development and utilization of hospital services,

(Continued on Page 423)



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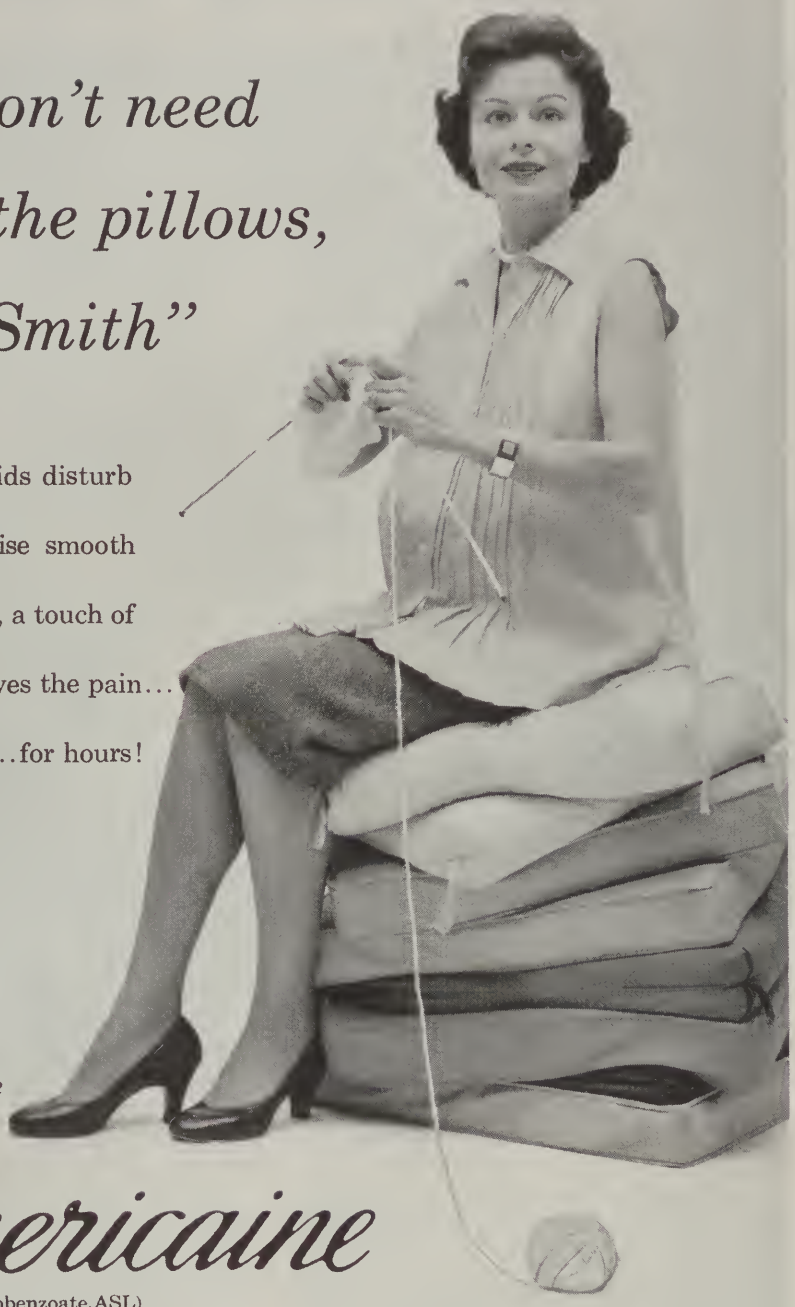
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Ascorbic Acid (as sodium ascorbate)	500 mg.
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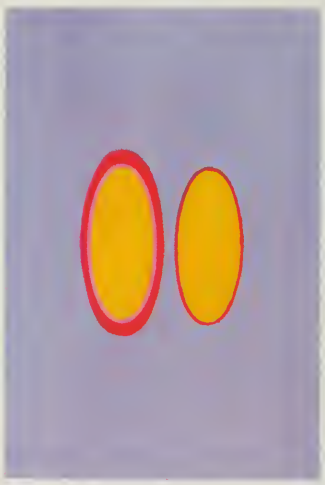
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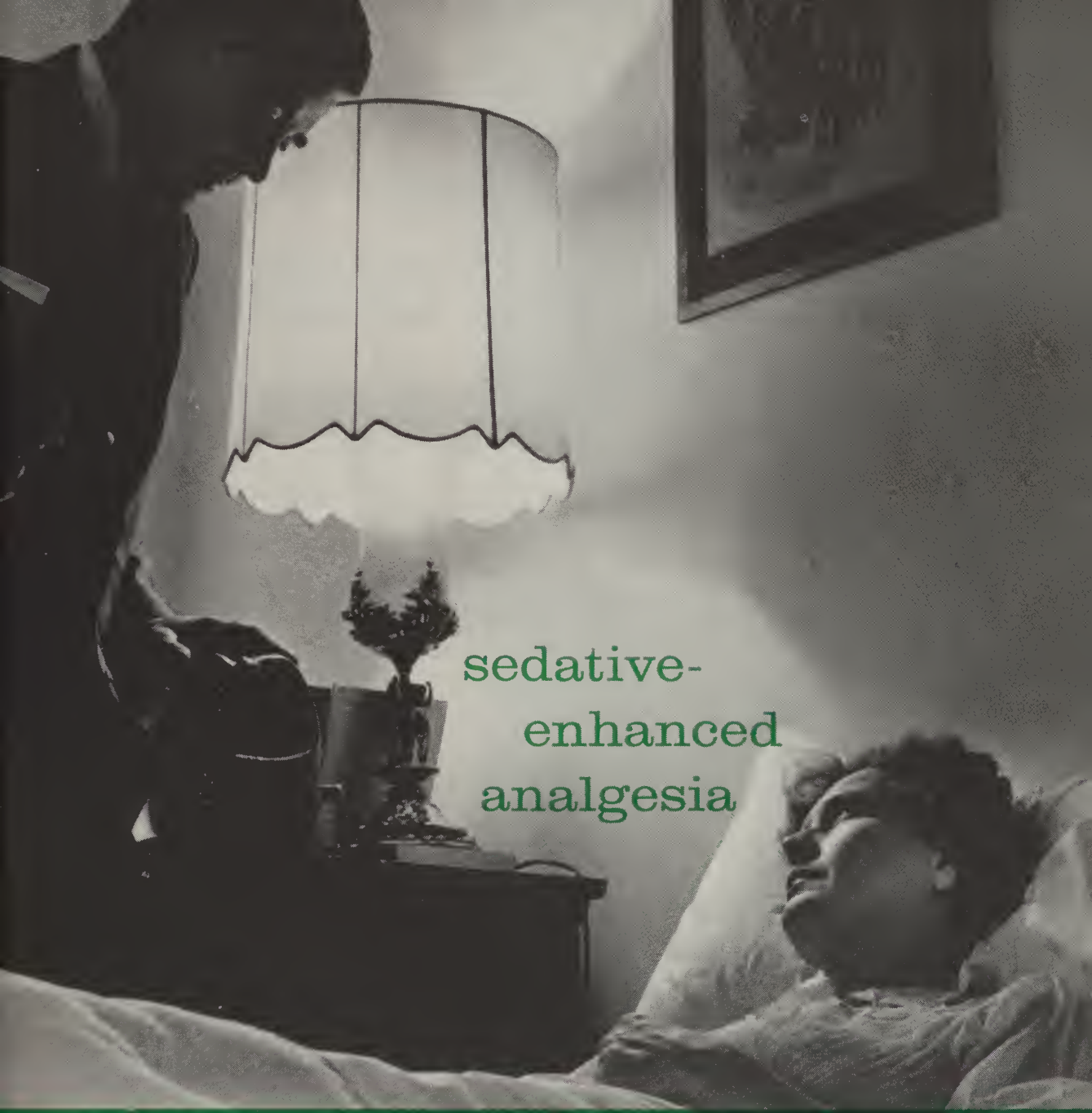


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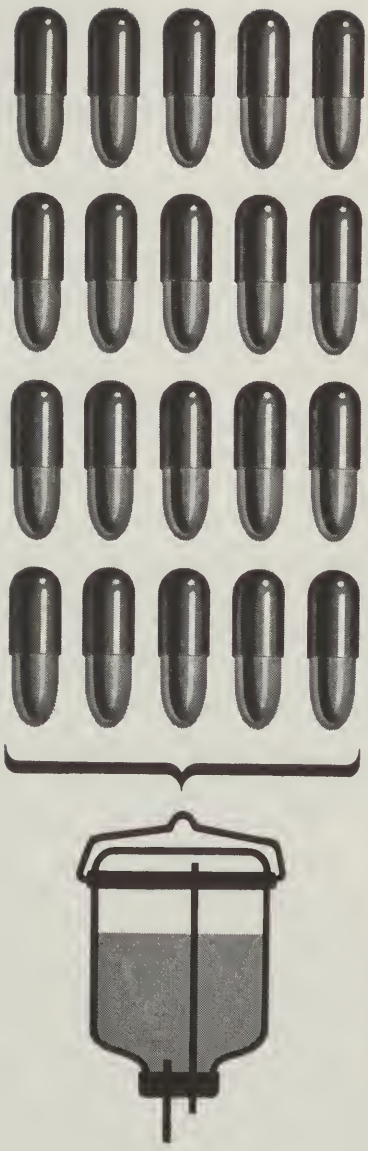
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Case history courtesy of Joel Goldman, M.D., Johnstown, Pa.
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Restorative Arterial Surgery In Individuals With Arteriosclerotic Gangrene Of the Lower Extremities*

J. HERMAN MAHAFFEY, M.D. †

Louisville, Ky.

The restoration of major arterial continuity with a resulting useful limb is feasible in a greater number of patients undergoing leg amputation than is generally realized

RESTORATIVE arterial surgery has been extended in peripheral arteriosclerotic occlusive disease from the individuals whose sole symptom is intermittent claudication to those with gangrenous or pregangrenous changes in the foot. It has not been too long ago that the patient with gangrene of the toes or distal portion of the foot resulting from a femoral or popliteal artery occlusion was subjected to a series of operations. Initially, amputation of the digit was done. When healing failed to occur, a transmetatarsal amputation or a below-the-knee amputation followed. Finally a supracondylar amputation ensued.

Eventually the fruitlessness of this approach —the multiple operations sometimes referred to as "whittling," the prolonged periods of hospitalization and convalescence, and the economic hardship imposed on the patient— was recognized and such individuals were given a supracondylar thigh amputation forthwith. Now, however, in 20 to 30 per cent of patients[4, 5] admitted for leg amputation, it is found feasible to restore major arterial continuity with a resulting useful limb, either asymptomatic or nearly so, with the loss only of that tissue which was already necrotic.

Material

The material presented includes, in addition to those patients undergoing restorative arterial surgery for gangrene of a portion of the foot, those with pregangrenous changes. For this purpose the two conditions included under pregangrenous changes by Roberts and Hoffman[5] have been utilized, "(a) ischemic ulcers which have shown no evidence of healing under a rigid program of 'medical' therapy and

*Read before the eleventh annual meeting of the Kentucky Surgical Society at French Lick, Indiana, May 16, 1960.

† From the Department of Surgery, University of Louisville School of Medicine.

(b) ischemic 'rest pain' of sufficient severity to warrant amputation."

Beginning in 1957 and through April 1960, 15 patients in these categories have been operated on, either undergoing a by-pass procedure, resection and grafting, or thromboendarterectomy. Of these 15 patients, six had gangrene of one or more toes and nine had either rest pain or ischemic ulcers. The findings and results in these two groups are summarized in Tables 1 and 2.

The occlusion was chronic in all cases except for two in the pregangrenous group. All but one would have required an immediate amputation. Immediate success was obtained in 13 of the 15 patients undergoing restorative arterial surgery. The two failures had early thigh amputations.

In the successful group, one aortic to bilateral popliteal by-pass and six common femoral to popliteal by-pass procedures were done. In addition, one woman had a common femoral to popliteal by-pass performed on the opposite limb for claudication. Occlusion recurred in three of the femoral to popliteal by-pass group at 12½, 13, and 17 months, resulting in one supracondylar amputation.

One death occurred from pulmonary embolus before amputation could be done, and the third still has his limb with a return of the claudication. Three femoral to popliteal grafts have remained patent for 6, 27, and 12 months, the latter patient dying of cancer with the prosthesis remaining patent until the end. The aortic to bilateral popliteal by-pass for occlusion of both superficial femoral arteries and incomplete occlusion of the common iliacs has remained patent for 28 months.

Three patients had iliac artery occlusions, one of which was acute. Thromboendarterectomy of the common iliac artery was performed in two, and in the third, resection of the common and external iliac arteries with insertion of a knitted Dacron artery prosthesis was done. These vessels are still patent at 19, 27, and 39

TABLE I

Summary of Patients with Gangrene of Lower Extremity Undergoing Restorative Arterial Surgery*

Case No.	Sex	Age Yrs.	Findings	Candidate for Immediate Amputation	Diabetes Years	Other Evidence of Severe Vascular Involvement	Run-off Shown by Arteriogram	Type of Prosthesis	Surgery	Length of Follow-up Mos.
1.	M	57	Gangrene, 1t. great toe; rest pain	Yes	—	None	Good	Nylon	Aortic-bilat. popliteal by-pass, 12-23-57. Amputation toe, 3-8-58.	(28) Asymptomatic
2.	M	62	Gangrene, 1t. great toe	Yes	—	Myocardial infarction; hypertension	Good	Nylon	Common femoral-popliteal by-pass, 4-2-57.	(23) Asymptomatic. End of toe sloughed and healed.
3.	F	42	Gangrene, 1t. 1-2-4 toes	Yes	—	None	Good	Nylon	Common femoral-popliteal by-pass 4-17-57.	(23) Thrombosis at 13 mos. Two other by-pass procedures with short-term results. Supracondylar amputation, 3-23-59.
4.	M	63	Gangrene, 1t. 1-2-4 toes; gangrenous ulcer, leg	Yes	—	Cardiac arteriosclerosis; congestive failure	Fair	Nylon	Common femoral-popliteal by-pass, 3-10-58; amputation 1t. 1-2-4 toes and skin graft ulcer, 3-22-58.	(12-1/2) Thrombosis at 12-1/2 mos.; died 4-10-59 of pulmonary embolus.
5.	M	59	Gangrene, 1t. great toe	Yes	—	None	Fair	Nylon	Common femoral-popliteal by-pass, 7-3-58; amputation 1t. great toe, 7-11-58.	(20) Thrombosis at 17 mos.; return of claudication
6.	M	45	Gangrene, 1t. 2nd toe	Yes	1/4	Radial pulses absent; pedal arteries calcified	Good	—	Thromboendarterectomy, popliteal; lumbar sympathectomy; amputation 2nd toe, 1-10-59.	(14) Subplantar abscess with pressure necrosis, resulting in gangrene plantar aspect foot and ankle (untreated): dorsalis pedis pulse present, BK leg amputation, 4-1-60.

*Table patterned after Roberts and Hoffman.[8]

TABLE 2

Summary of Patients with Ischemic Ulcers or Ischemic Rest Pain of Lower Extremity Sufficient to Warrant Amputation (No Improvement with Conservative Therapy) Undergoing Restorative Arterial Surgery*

Case No.	Sex	Age Yrs.	Findings	Candidate for Immediate Amputation	Diabetes Years	Other Evidence of Severe Vascular Involvement	Run-off Shown by Arteriogram	Type of Prosthesis	Surgery	Length of Follow-up Mos.
7.	M	44	Acute occlusion; impending gangrene, rest pain; anesthesia	Yes	—	None	Not Done	—	Thromboendarterectomy, rt. common iliac, 1-17-57 (Acute occlusion superimposed on chr. incomplete occlusion).	(39) Asymptomatic
8.	M	51	Impending gangrene, lt. great toe	No	—	None	Good	—	Thromboendarterectomy, lt. common iliac, 2-6-58.	(27) Asymptomatic
9.	M	73	Ischemic ulcer, lt. foot; rest pain	Yes	—	None	Fair	Nylon	Common femoral to popliteal by-pass, 4-2-58	(12) Died 4-6-59 of cancer. Graft still patent.
10.	M	60	Ac. occlusion, rt. common femoral; rest pain; anesthesia; paralysis; chr. occlusion distal sup. fem. artery	Yes	—	Myocardial infarction	Poor; only anterior tibial patent	Nylon	(1) Thromboendarterectomy, common femoral, 5-9-58; (2) external iliac to popliteal by-pass, 5-24-58.	Acute occlusion of by-pass graft; supracondylar amputation
11.	M	77	Impending gangrene, lt. 2-4 toes; rest pain	Yes	—	Cerebral and cardiac arteriosclerosis	Good	Dacron	Resection lt. common and external iliacs; insertion of Dacron prosthesis, 8-19-58.	(19) Asymptomatic
12.	M	75	Rest pain	Yes	—	Hypertension	Poor; prox. popliteal occluded; popliteal bifurcation occluded	—	Thromboendarterectomy, proximal portion of popliteal, 1-16-59	(12) Relief of rest pain; foot warm; no return of pedal pulses
13.	M	53	Impending gangrene, rt. 1-4 toes & dorsum of foot; rest pain; (paraplegic)	Yes	—	None	Fair	Nylon	Resection of distal sup. fem. a. & prox. pop. a. & insertion of graft after unsuccessful thromboendarterectomy, 4-27-59.	Acute thrombosis; supracondylar amputation, 4-30-59
14.	F	62	Ischemic ulcer, rt. ankle; rest pain	Yes	—	Cardiac arteriosclerosis; congestive failure; hypertension	Good	Dacron	Common femoral to popliteal by-pass, 11-6-59; similar procedure on left, 11-13-59.	(6) Asymptomatic
15.	F	65	Acute occlusion; impending gangrene of foot & leg, rest pain; anesthesia	Yes	—	Hypertension; congestive failure	Fair	—	Thromboendarterectomy, popliteal; unsuccessful retrograde flush thrombectomy via post. tibial at ankle, 4-3-60.	(1) Dorsalis pedis pulse present; cutaneous gangrene & infection about medial malleolus at incision

*Table patterned after Roberts and Hoffman.[5]

months, and the pedal pulses are palpable in these individuals.

Immediate failure was encountered in a 53-year-old paraplegic with impending gangrene in whom resection of the distal portion of the superficial femoral artery and proximal portion of the popliteal artery was necessary with insertion of a Nylon prosthesis after an unsuccessful thromboendarterectomy. The procedure was fraught with difficulty, the patient having contractures of all joints in the lower limbs, with knee extension contractures of 160°. In addition, technical difficulties occurred with the use of the endarterectomy stripper which ultimately required grafting of the vessel. A supracondylar amputation was done three days later.

A 75-year-old man was seen for amputation because of severe ischemic rest pain. There was complete segmental occlusion of the proximal portion of the popliteal artery and of the popliteal bifurcation with large collaterals coming in and out of the patent intervening segment. Thromboendarterectomy of the proximal occlusion was successfully accomplished, with relief of the rest pain, warming of the foot and preservation of the limb. Pedal pulses were not restored because of the distal obstruction.

A combination of procedures was used in a

60-year-old amputee who underwent an emergency thromboendarterectomy for acute thrombosis of the common femoral artery. Arteriography at that time revealed a chronic segmental occlusion of the distal portion of the superficial femoral artery. Nevertheless, it was felt that correction of the distal occlusion could be delayed and anticoagulant therapy was instituted. Calf pain and tenderness persisted for five days after the initial surgery. Fifteen days later, without further arteriography, an external iliac to popliteal by-pass was done and met with immediate failure. A supracondylar amputation was performed shortly thereafter.

Had arteriography been performed prior to the second procedure, it might have revealed small artery thrombosis in the leg, the result of his initial occlusion, and perhaps the second procedure might not have been undertaken. However, it was thought that this remaining leg would not have long survived the trauma of walking, either with crutches or a prosthesis, and accordingly the second operation was undertaken.

Thromboendarterectomy for an incomplete popliteal occlusion together with lumbar sympathectomy and amputation of a gangrenous toe was successfully accomplished in a 45-year-old diabetic. A below-the-knee amputation was required 14 months later for extensive gangrene, infection, and slough of the foot due to an untreated subplantar abscess. At the time of amputation, the dorsalis pedis pulse was still present.

Illustrative Cases

The following cases are presented to illustrate some of the problems encountered.

CASE 1. A 57-year-old pipe-fitter was admitted to the Kentucky Baptist Hospital on December 19, 1957, with partial loss and gangrene of the left great toe, and edema and cellulitis of the left foot and leg (Fig. 1). For five months he had had pain, swelling and color changes in the left great toe. Severe ischemic pain had been present for a month and he was unable to straighten his leg. Bilateral intermittent calf claudication had existed for three years. In addition to the findings previously described, examination revealed both femoral pulses to be diminished, and the popliteal and pedal pulses absent.

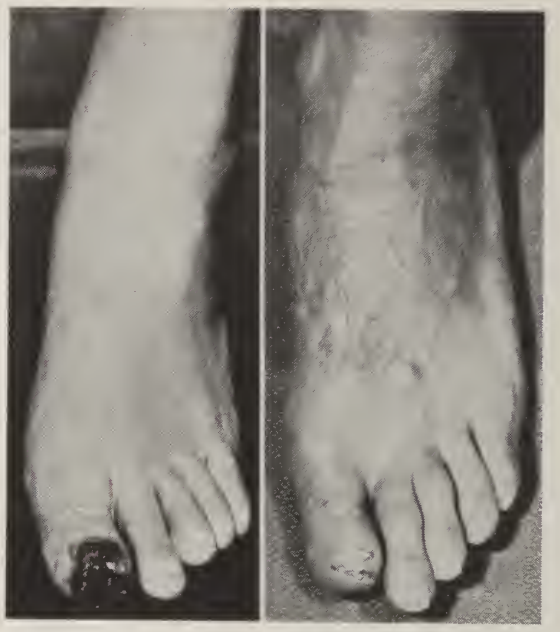


Figure 1 Figure 2

Figure 1—Gangrene of left great toe, and edema and cellulitis of foot and leg, preoperative (Case 1); Figure 2—Postoperative photograph of foot after open amputation of distal phalanx of great toe.

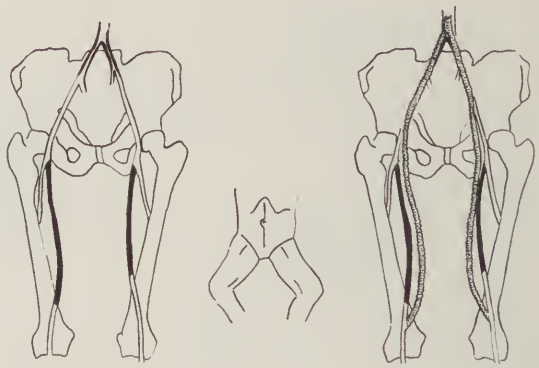


Figure 3

Diagram illustrating abdominal aortic to bilateral popliteal artery by-pass, using a crimped nylon aortic bifurcation prosthesis (Case 1). Findings revealed by aortography are shown.

Aortography revealed considerable disease of both common iliac arteries with incomplete occlusion on the left, complete occlusion of both superficial femoral arteries, and patent popliteal arteries. An abdominal aortic to bilateral popliteal artery by-pass was successfully performed, using a crimped Nylon aortic bifurcation prosthesis (Fig. 3). Open amputation of the distal phalanx of the left great toe was done 2½ months later with eventual healing (Fig. 2). The by pass graft has remain-



Figure 4 Figure 5

Figure 4—Gangrene and ulceration of the left great, second and fourth toes, and blotchy cutaneous gangrene of dorsum of foot, preoperative (Case 4); Figure 5—Postoperative photograph of foot after amputation of three gangrenous toes.



Figure 7 Figure 8

Figure 7—Gangrenous ulcer of left leg, preoperative (Case 4); Figure 8—Postoperative photograph of leg after skin-grafting of gangrenous ulcer.

ed patent for 28 months and the man is free of symptoms.

CASE 4. A 63-year-old banker was seen at Norton Memorial Infirmary on March 4, 1958, for gangrene and ulceration of the left great, second and fourth toes, blotchy cutaneous gangrene of the dorsum of the foot, and a gangrenous ulcer of the leg (Figs. 4-7). A left lumbar sympathectomy had been done four weeks earlier. Extensive arthritis involving the hands, knees, ankles and feet for approximately 20 years had so limited his activity that he never experienced claudication. Examination revealed the pulses distal to the femoral to be absent on the left. The dependency edema of both feet was probably due to the ischemic rest pain. Arteriography revealed considerable disease of the left superficial femoral artery and proximal portion of the popliteal artery with complete occlusion in the midportion of the femoral.

A common femoral to popliteal by-pass using a Nylon tube was successfully performed on March 10, 1958 (Fig. 6). Amputation of

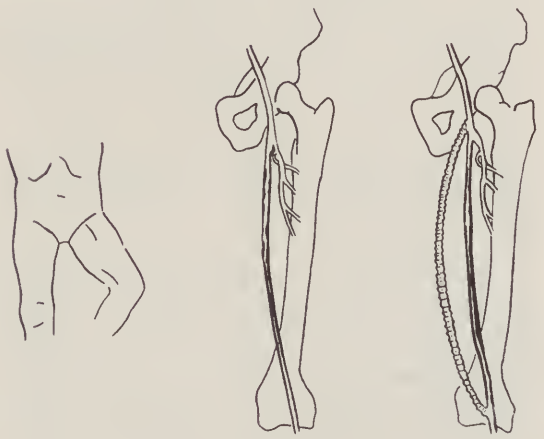


Figure 6

Diagram illustrating common femoral to popliteal artery by-pass, using a crimped nylon tube (Case 4): Findings revea'ed by arteriography are shown.

the three involved toes and skin grafting of the leg ulcer was done 12 days later with healing (Figs. 5-8). He remained asymptomatic until 12½ months later when acute thrombosis of the graft occurred. He died on April 10, 1959, of a pulmonary embolus while awaiting a supracondylar amputation.

CASE 5. A 59-year-old coal-miner was admitted to the Kentucky Baptist Hospital on June 28, 1958, with gangrene of the left great toe. This occurred in January following removal of the toenail for infection beneath it. A left lumbar sympathectomy had been done in May. No history of intermittent claudication was obtainable. Examination revealed the left popliteal and pedal pulses to be absent, and in addition to gangrene of the distal phalanx of the left great toe, there was cellulitis and induration of the adjacent portion of the foot. Arteriography revealed incomplete occlusion of the left superficial femoral artery distally and complete occlusion of the proximal portion of the popliteal artery.

A left common femoral to popliteal artery by-pass, using a crimped Nylon tube, was successful on July 3, 1958, and amputation of the distal phalanx of the great toe was done eight days later. He remained asymptomatic for 17 months until acute thrombosis of the graft occurred. The claudication returned but the limb remains viable.

Discussion and Summary

Restorative arterial surgery in patients such as these is fraught with difficulties and failures. There are authors[2, 3] who feel that these procedures are not indicated while others[1, 4, 5] report encouraging results with surgery in individuals with pregangrenous and gangrenous changes in the foot.

In this group of 15 patients who underwent restorative arterial surgery, either a by-pass procedure, thromboendarterectomy, resection and grafting, or a combination of two of these procedures, there were two immediate failures resulting in supracondylar thigh amputations during the same hospital stay. There were four late failures occurring at 12½, 13, 14 and 17 months, resulting in two eventual amputations, one a supracondylar thigh amputation and in the other a below-the-knee amputation. Death from a pulmonary embolus occurred in one patient before amputation could be done. The fourth, who still has his limb, has had a return of his intermittent claudication.

There are eight patients whose arterial procedures have remained patent for periods of 1, 6, 12, 19, 23, 27, 28 and 39 months. In addition, one 77-year-old man's leg was salvaged, with relief of a proximal popliteal occlusion by thromboendarectomy, although the popliteal bifurcation was obliterated. The age range of patients with gangrene was 42 to 63 years. The age range of those with pregangrenous changes was 44 to 77 years, three patients being 73, 75 and 77.

During this same period 17 individuals, in whom there were no clinical indications for restorative arterial surgery, underwent 19 amputations, thigh and leg, for arteriosclerotic gangrene. The individuals in this group were somewhat older than those who underwent restorative arterial surgery.

On the basis of this limited number of cases, it would seem all individuals 70 years of age or under, who are candidates for amputation of the lower extremity because of gangrenous or pregangrenous changes of the foot of arteriosclerotic origin, should have arteriography routinely prior to amputation. In conclusion, it is again emphasized that in patients who are admitted for leg amputation, it is feasible to restore major arterial continuity with a resulting useful limb, either asymptomatic or nearly so, with loss of only that tissue which was already necrotic, in a greater number than is generally realized.

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Gastrointestinal Perforation In Infancy and Childhood

Diagnostic and Management Woes In 10 Cases*

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Perforation peritonitis in the young demands early recognition, vigorous treatment. Administration of intravenous fluids and antibiotics paves way to direct surgical management

PERFORATION peritonitis, in infancy and childhood, is always a devastating, often a deadly, disease. It can be avoided if congenital or acquired lesions of the gut are recognized at an early stage. Occasionally, the physician is not called in until the storm has already broken. In this setting, simple diagnostic measures and vigorous intravenous fluid therapy plus antibiotics, followed by timely operative intervention, are endorsed.

Analyses of peritonitis in childhood seldom point out that in general practice, successive cases of even the most common entity may present themselves decades apart. In practice, academic data may make little difference to the family doctor. The big question is what to do, in detail, with this case of peritonitis.

Diagnosis

At the outset, the diagnosis is imperative. Though peritonitis is peritonitis, just as pigs is pigs, the wide range of causative entities thickens the plot. Size of perforation and composition of the insult may dictate both degree and rapidity of deterioration. However, even with a careful history and physical examination, preoperative definition of the exact cause of the visceral catastrophe may be impossible. Without minimizing the virtues of anatomical diagnosis, it seems far more productive to agree that the peritoneum has been seriously assaulted, bearing down at this point, on thorough evaluation and almost simultaneous correction of the physiological deficit that is the keystone of effective care.

First Steps

Once the over-all setting of peritonitis is recognized, steps are taken to: (1) judge the level of perforation and degree of contamination, using one's own wits aided by uninvolved x-ray and laboratory measures; (2) size up and correct the fluid, salt, protein and blood depletion that has come to exist; (3) administer an appropriate amount and type of antibiotic on the basis of the probable site and stage of perforation; (4) prepare for surgery, where both diagnosis and treatment must continue, and; (5) if surgery is employed, realize that the patient's depletion noted above must be further corrected following operation. In other words, diagnostic and therapeutic maneuvers go hand in hand. Both may be abetted by prompt and adequate sedation of a desperately ill, but still combative, infant or toddler.

Operation?

This uncertainty implies that peritonitis in the young is not always a ruptured appendix (about 70% in a large series previously re-

*Presented at a joint meeting of the Twelfth Councilor District and the Fifteenth Councilor District, May 5, 1960, at Cumberland Falls, Kentucky.

viewed).[1] As will be pointed out by the case studies to be presented, this is important, for while some may conservatively manage appendiceal perforation in its advanced stages, all might concur in the operative approach to the less common leaking hole in the gastrointestinal tract elsewhere. In infancy, when congenital intestinal anomalies are ripe for trouble, we must expect the unexpected, the one case in a lifetime. Peritonitis with but few exceptions demands timely intervention.

In any event, the first aid in making at least a working diagnosis is awareness of possibilities. The following cases point up the wide range of gastrointestinal maladies that affect these little ones and, surely, should make one leery of managing peritonitis conservatively, i.e. without operation. While these brief summaries omit the details of each child's illness (the number, appearance and amount of vomitus, stools, and other depletion factors), once again their importance, in terms of both diagnosis and, especially, treatment, must be emphasized.

CASE 1—T.P.: a 3-year-old female. This child had a three-day history of a fall with a questionable head injury. She was variably listless or irritable and had practically no oral intake. She was noted to drool and to hold her head to the left side. On examination, there were no other localizing signs. A differential of some cervical-vertebral injury or a sub-dural hematoma with a weird neurological deficit was proposed. Lo and behold, a jack jutting out from the esophagus on the left side just above the thoracic inlet, was found serendipitously on the cervical x-rays. At open operation (resorted to when esophagoscopy extraction failed), the jack was removed and the esophagus repaired. The child has been well since operation.

CASE 2—P.H.: a one-year-old female. This little girl developed an enlarging inflammatory mass in the anterior superior aspect of the right side of her neck. A baby-food jar had been found to be fragmented and this was the suspected reason for the neck infection. The child was unable to eat for approximately 24 hours, and, though febrile, was otherwise in excellent condition. X-rays revealed a fistulous communication from the esophagus into a periesophageal abscess. At surgery, shortly thereafter, a glass fragment was removed and the area drained. A temporary fistula developed but this closed spontaneously and the result has been excellent.

While both of these youngsters were somewhat dehydrated by an inadequate intake for a period of one or more days, early operation spared them from further depletion including the more devastating effects of mediastinitis (closely akin to peritonitis). The small size of the perforation in a fairly well encompassed area also lessened morbidity.

CASE 3—W.M.: a newborn male infant. This infant was born weighing 5.5 pounds and failed to tolerate any feedings. Progressive addominal distention was noted and abdominal x-ray revealed the presence of free air and peritoneal flecks of calcification. The diagnosis of meconium peritonitis was made and, at operation, a perforated ileal ulcer was identified and closed. Recovery was uneventful.

CASE 4—S.G.: a newborn female infant. This premature was born weighing just over 3 pounds. Her course, characterized by severe abdominal distention, was similar to that of the preceding case and, at surgery, an atresia of the ileum was found with a blow-out of the proximal end. An end-to-end ileoileostomy was performed, with a successful outcome.

Both of these cases, though critically ill, could be approached with some confidence as the diagnosis of meconium peritonitis with some form of gastrointestinal disruption was established shortly after birth and depletion and bacteriological invasion were relatively limited. The use of a complementary gastrostomy for postoperative decompression and, later, feeding, aided significantly.

CASE 5—D.B.: a 2½-year-old boy. This patient had a four-day history of abdominal pain and vomiting, followed by abdominal distention. He had the picture, on admission, of severe peritonitis with extensive dehydration and sepsis. Vigorous fluid and antibiotic therapy was followed by early surgery, with the exteriorization of a gangrenous loop of ileum, the site of volvulus. Although he almost died during the operation, his postoperative recovery was excellent and the ileostomy was later closed, with an excellent result.

CASE 6—E.R.: a 2-9/12-year-old female. This girl had a seven-day history consistent with appendicitis and was almost moribund on admission. The father, extremely vague as to details, had been away from home for the child's entire illness. After vigorous fluid and antibiotic therapy over a period of almost 24 hours, a laparotomy was performed, revealing a severe E. coli purulent peritonitis. No lesion, however, became evident. The child died two days following the operation, of overwhelming sepsis and at autopsy, a rectal perforation in free communication with the peritoneal cavity was found. This was thought to be traumatic in origin, probably trans-anal, with the child possibly having fallen on a toy.[1]

I believe these last two cases vividly emphasize the inadvisability of too readily making the diagnosis of far advanced complicated appendicitis with the hope that prolonged conservative management might eventually make the child a better operative risk or possibly a candidate for interval appendectomy. Case 6 tragically warns against leaving the surgical scene without proper resolution of the peritonitis problem!

CASE 7—D.D.: a 7-year-old white male. This boy had been treated for severe bouts of abdominal pain, thought to be due to a duodenal ulcer on the basis of two gastrointestinal series. Conservative treatment had been instituted with little relief. He had had one bout of melena with subsequent anemia. Shortly before admission, he had been seized with sudden severe abdominal pain and developed a board-like abdomen. Following fluid and antibiotic therapy, operation disclosed a perforated Meckel's diverticulum which was resected uneventfully. There was no evidence of a duodenal lesion. The boy has been entirely well to date.

CASE 8—L.B.: a 3-year-old girl. This child had a four-day history of abdominal pain, vomiting, severe diarrhea, distention and fever. She presented, on examination, a RLQ abscess and obvious generalized peritonitis. After vigorous fluid and antibiotic therapy, appendectomy with drainage of a large abscess was performed. Postoperatively, she developed a pelvic abscess which drained per rectum. Two weeks later, unrelenting intestinal obstruction necessitated an ileo transverse colostomy by-passing the site of adhesive obstruction in the pelvis. Out of the blue, after six prosperous months, she died during a six-hour bout of apparently overwhelming viremia with gastro-enteritis. At autopsy, it was of great interest to note the almost complete resolution of the previous abdominal catastrophe. Death was in no way related to previous surgery.

The policy of operating on all cases of peritonitis, including complicated appendicitis, is not always without grief. This case is presented to recognize the dilemma that exists regarding this formidable lesion. Surely, some would state that this youngster's course might have been more benign had immediate operation been forestalled, resolution of the inflammatory process awaited and interval appendectomy elected. On the other side of the fence, the fact that a RLQ abscess was present and apparently gave rise to the generalized peritonitis encountered, emphasizes the unreliability of the average child's walling off mechanisms, centering on the appendix or otherwise.

CASE 9—B.J.: a 7-year-old boy.[1] This patient's father became enraged and blasted the patient and his brother with a shotgun. Hit in the buttock, B.J. developed signs of peritonitis. On proctoscopy, there was a question of a rectal perforation. At laparotomy, the recto-sigmoid was intact, but the small bowel contained multiple holes which were closed, the patient making an eventful recovery.

CASE 10—P.W.: a 2-year-old girl, was struck by an automobile head on and brought to the hospital in deep shock. Signs of peritonitis were outstanding. Beginning to respond but still critical after vigorous intravenous fluid and whole blood transfusion, laparotomy was performed. As the peritoneum was entered, a large amount of bloody reactive fluid was removed, uncovering a small liver laceration, a contused right colon and a completely transected terminal ileum. Peritoneal lavage was done to complement a by-pass ileo transverse colostomy. Hepatic repair was not necessary. Even while finishing the operation, she improved and her recovery has been complete.

These cases of gastrointestinal perforation in infancy may whet your appetite for diagnosis when confronted with a child having a "sick abdomen." Even more, they illustrate the de-

terioration factors, dramatically or insiduously present in all gastrointestinal perforations. Each is a catastrophic event—an economic parallel would be a run on the bank. (Table I)

TABLE I

Body Fluids-Basic Banking

Circulating Blood Volume (C.B.V.)	Checking Account
Fluid Bathing Cells (I.S.F.)	Savings Account
Fluid In Cell (I.C.F.)	Federal Reserve

The following is a tabular accounting of what happens.

A. Prodromal Phase—gastrointestinal dysfunction (Table II)
   (1) Refusal to eat or anorexia
   (2) Pain and irritability due to inflammatory element of lesion
   (3) Regurgitation or frank vomiting — at times irritative diarrhea
   (4) Progressive obstruction due to mechanical or inflammatory factors or both—distention with fluid and air

B. Actual Perforation Phase (Table III)
   (1) Burn-like insult to peritoneum
   (2) Severe ileus with massive pooling of fluid in the bowel

C. Peritonitis Phase
   (1) Local inflammatory response with burn-like fluid loss into and around peritoneum continuing—combined chemical and bacterial etiology
   (2) Bacterial infection of peritoneum with toxin production and either bacteremia or toxemia affecting hepatic, renal and cardiopulmonary function
   (3) Gastrointestinal dysfunction continues as in Phase A

D. Response to Surgery Phase
   (1) Tissue trauma and hemorrhage losses
   (2) Metabolic, including endocrinological upheaval affecting water and salt economy

E. Postoperative Phase
   (1) Peritonitis phase continues
   (2) Iatrogenic problems such as antibiotic toxicity, transfusion reaction, surgical complications enter; suction losses have to be considered.

TABLE II

A. Early* Deterioration In G.I. Perforation

Refusal to eat or drink Vomiting or Diarrhea Inflammation	Depletion of Fluid and Salt	Savings and Reserve drawn on

* Also Later Postoperative

TABLE III

B. Acute Deficit Of G.I. Perforation

Perforation Burn Peritonitis	Depletion of C.B.V. Drain on Tissue Fluids	Run on Bank

Each child depleted in varying degrees needs prompt treatment as shown in Table IV. Some need immediate operation to prevent further deterioration, others need intensive management before surgery.

TABLE IV

Treatment Of G.I. Perforation

Restoration For Operation	Intravenous Therapy Builds Up C.B.V.	Deposits
Surgery →	Fire Put Out-Perforation Closed	and
Completion of Care	Continuous I.V. Deposits Fluid + Salt C.B.V. ➤ I.S.F. ➤ I.C.F.	Reserve built up

The next table (V) summarizes the treatment of a typical case, giving the calculations for fluid replacement in terms of quality, quantity and rate of administration. Simultaneously, parenteral antibiotic therapy may need to be not only massive but all inclusive, using several agents.

Intravenous Fluid Therapy

Early depletion as shown in Table II is interstitial and intracellular sodium and potassium containing fluid loss that has come on gradually. A ten to twenty per cent of body weight deficit is not uncommon. That which has been lost gradually must be replaced in some moderation as shown in Table V.

The burn-like loss of the perforation (Table III) frequently precipitates admission of the child. The peritoneal plasma-like weeping can best be accounted for by blood and balanced

electrolyte solution on the basis of the Evans-Burn Formula. (Table V)[2] As soon as the blood becomes available and urine flow* is established from interim dextrose in saline therapy, it should be given rapidly.

Current water and salt needs, including a continuing "make-up" of earlier depletion losses are well handled with a fairly dilute balanced electrolyte solution (Polysal M-Cutter). Usually 5 cc. per kilogram per hour (twice the usual basal water requirement) will maintain a urine output of 25-30 cc per hour.

These guide lines must be individualized in keeping with the patient's response, new findings and encountered problems. (Recall the difference between Cases 9 and 10.)

Conclusions

The infant with severe peritonitis is always a severe challenge. An orderly, vigorous approach in the first hour is essential. Peritonitis, almost without exception, indicates laparotomy as soon as fluid and electrolyte restitution is well under way and the patient's vital signs are tending towards normal. Preoperative anatomical definition of the site of visceral perforation is desirable, but not always attainable, and should not deter appropriate surgical action.

A small Foley catheter should be inserted as treatment is started.

TABLE V

13-pound infant (5 Kilogram) with G.I. Perforation-INTRAVENOUS THERAPY

Early Depletion A	
10% of body weight	500cc 5%
.10x5Kg 0.5Kg	Dextrose/Saline*I. V.
rapid I. V. 1/4 x 500cc	125cc
Remainder at 50-75 cc/hr	375cc
Burn Like Phase B	
15% surface third degree burn	
15x5	75cc Blood#
15x5	75cc Balanced electrolyte
As of Evans Formula in burns	solution
Current hourly needs	
urine, sweat and lung loss	
5cc/Kg/hr	600cc (total) balanced
24x25	electrolyte solution
	1250cc total in 24 hours

* 10 Gm. of serum albumin can be added here

\# Blood can be given as soon as available in 20-30 minutes

Additional blood should be available for operative loss, viz. 250cc

When necessary, any deficiencies in diagnosis may be corrected during surgery. Corrective measures should be complete and direct. Postoperative care is the well-timed completion of the treatment started on admission.

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Differential Diagnosis of Infantile Hypotonia

Hypotonia is present when there is a decreased amount of spontaneous movement, reduced response to postural demands, and a lack of resistance to passive motion. The final diagnoses in 31 cases of infantile hypotonia referred to the authors as diagnostic problems were almost equally divided between brain damage and motor unit diseases. Cases diagnosed as having brain damage tended to have abnormal birth histories, normal electromyograms, and to show reduced mental and motor capacity and many abnormal neuromuscular patterns on Gesell examination. It is of interest that 2 of these cases had evidence of motor unit disease as well. Patients with motor unit diseases tended to have normal birth histories, abnormal electromyogram and normal Gesell examinations except for decreased motor ability.

—R. H. Jebsen and others, American Journal of Diseases of Children (Jan.) 1961

Man-Made Disease*

The Changing Patterns Of Disease and Occupation

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Disease may result from changes in man's environment. The medical practitioner must be aware of this possibility and include it in the differential diagnosis

THE type of object familiar to us in our daily activities has changed within the lifetime of those living to as great an extent as at any time in recorded history. This change is apparently accelerating rather than decclerating. The change we have witnessed and are witnessing has been accompanied by changes in our pattern of living and ways of doing our daily tasks.

How much these changes of which I speak have affected the pattern of disease in man can only be conjectured, but there is little doubt that a few specific developments have in themselves had a great effect on the pattern of disease in the United States and to a great extent in the entire world. The development of chemotherapeutic agents and antibiotics has altered the pattern of morbidity and mortality in man, has decreased the fear of disease that at one time was the scourge of mankind, and has opcned the prospect of an era able to control diseases caused by microorganisms.

As the acute and chronic infectious diseases have become of less importance in relative numbers affected, other causes of disability have assumed a more prominent position in the statistical listings of causes of morbidity and mortality. Concomitant with this change in the style of disease has been an ever quickening change in our technology with an accompanying change in the pattern of work and the environmental milieu, at work, at home, and in the community. These changes have been notable for 200 years but have become particularly impressive during the past 50 years.

Where once our population was primarily employed in growing food and fiber to feed and clothe itself, today the population employed in agricultural industry is less than 10 per cent of our total population. The people who have left the farm have been absorbed into larger centers of population, subjected to closer contact with their fellow beings, working and living in a vastly different environment than their ancestors of 200 or cven 100 years ago.

The technology which has changed our way of life has introduced new health problems while overcoming many of the "traditional" diseascs. Aggregations of people have always promoted an increase in the "mass diseases." We have had considerable success in solving the problem of diseases of aggregations of people. The development of technology introduces other possiblc diseases. It is these latter on which we must concentrate our attention.

Man-Made Diseases

The development of a new technological process, a new chemical or a new industry always poses the possibility of the exposure of the worker and the people in the vicinity of the manufacturing plant to substances or energies to which they were not previously exposed. Any disease resulting from this technological change may legitimately be considered a "man

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made disease." Any disease which man creates is within his power to prevent! It is for this reason that an awareness of this category of disease is imperative for the medical practitioner. Only by recognizing the existence of a disease can its future occurrence be prevented.

The Pneumoconioses

Among the oldest of the man-made diseases are the pneumoconioses, dust disease of the lungs. Pneumoconiosis has been defined as: "Any dust particles retained in the lymphatic depots of the lungs." There are many pneumoconioses and more are being recognized. Unfortunately, in too many instances the diagnosis of silicosis is appended to all pneumoconioses without adequate investigation to determine that this is indeed the correct diagnosis. To diagnose silicosis one must have:

(1) a history of exposure to silica.
(2) a chest x-ray consistent with the diagnosis.

A history of exposure without changes indicative of disease is insufficient for a diagnosis, as is the x-ray film without an adequate history of exposure. Too frequently silicosis has been diagnosed when the correct interpretation would have been histoplasmosis, coal miners pneumoconiosis, bagassosis, or a myriad of other pulmonary diseases. Faulty diagnoses are not inconsequential. In many instances they can result in damage to the patient and to fellow employees, as well as lengthy and costly legal entanglements. The term pneumoconiosis does not imply fibrosis but merely indicates the accumulation of dust in the lymphatics of the lungs. Such accumulation may or may not have a significant physiological effect.

Among the dusts that are presently recognized as resulting in pulmonary fibrosis are:

(1) Silica
(2) Asbestos
(3) Bauxite Processing (Shaver's Disease)
(4) Diatomaceous earth
(5) Coal Dust
(6) Beryllium

Each dust causes a specific type of reaction and may result in physiological and pathological changes which are identifiable. Diagnostic criteria are as pertinent as in the diagnosis of varicella or rheumatoid arthritis.

Plumbism

As is true with so many disease entities, where the level of awareness is high, the diagnosis is made frequently; where the awareness is low, the opposite is true. In 1959 in New York City, Baltimore and Cincinnati, to mention but a few cities, more cases of lead poisoning were reported among children than ever before. Nothing had changed in these cities but the level of awareness of a few medical practitioners.

This is an important disease from a number of points of view. Lead poisoning can cause permanent incapacity or death. A child requiring institutionalization for the remainder of its life may represent a minimum cost of $100,000, disregarding the loss of a potentially productive human being. A second reason to emphasize lead poisoning is the preventable nature of the disease and the possibility of cure if diagnosed in time.

The diagnosis of lead poisoning in a child should be suspected if anyone of the following occur:

(1) Convulsions
(2) Repeated Vomiting
(3) Hypochromic Anemia
(4) History of Pica
(5) Abdominal Pain

In an adult, the symptoms are different but can be just as severe and debilitating. Exposure to lead may result in nausea and vomiting, weakness and anemia. Only in a far-advanced case of exposure to inorganic lead do we find nerve involvement, such as wrist and ankle drop. Diagnosis is confirmed by a history of exposure and analysis of blood and urine for lead.

This analysis is not a routine clinical analysis because of the risk of contamination by lead in the usual laboratory equipment. Porphyrins and stipple cell counts are suggestive but not diagnostic. Their absence does not eliminate the diagnosis, their presence does not confirm it.

Ionizing Radiation

Injury resulting from radiation exposure is relatively infrequent and has not been a serious problem. The majority of radiation injuries, if we exclude those resulting from the use of the Atom Bomb during the second World War,

have been the result of the misuse of radiation by medical and dental practitioners. The injury has occurred to the practitioner more often than to the patient and has often been a type of injury associated with excessive exposure to comparatively low levels of radiation over a long period of time.

Radiation dermatitis of the hands, hyperkeratosis, and subsequent malignant degeneration have been frequent sequelae of the faulty use of fluoroscopy. It is likely that there has also been an increased incidence of leukemia among those who have received excessive exposure to radiation. These are known positive findings. The disease syndrome following radiation exposure is well known and well documented. There should be little need for debate as to whether or not an injury or disease is due to radiation exposure. A detailed history of exposure and careful observation of the injury and its natural development should indicate without too much doubt whether or not radiation was the etiologic agent in most cases.

Control of radiation exposure is best achieved by careful attention to the source of the radiation and its proper management. Surveillance of those necessarily exposed to radiation is necessary in order to limit the exposure to an absolute minimum and to keep a record of the actual exposure. White blood counts and other biological determinations cannot be relied upon as a means of determining exposure to x or gamma radiation. Film badges or dosimeters should be used and blood counts abandoned as a means of surveillance.[2, 3]

The increasing use of radiation need cause no additional injury if those responsible continue to be aware of the attendant hazards. In this respect the medical and dental professions have, until quite recently, been woefully remiss. At the present time unnecessary radiation exposure could be reduced quickly and easily if each physician merely took the trouble to bring his radiographic equipment up to present safety standards.

Benzol

The realization that benzol (or benzene as it is frequently called) can cause bone marrow depression and aplastic anemia has resulted in the limitation in its use in many industries. However, it is an essential chemical for which there is no substitute in a number of industrial processes. When used under carefully controlled conditions exposure to the worker is practically zero. If not controlled, benzol exposure can result in severe bone marrow depression and death.

Agricultural Chemicals

Since the second World War there has been a revolution in agricultural practice in this country. The introduction of organic pesticides and the increased use of fertilizer have resulted in an explosive increase in production. It is quite unlikely that these new practices will be changed, but it is more likely that yet more chemicals will be introduced into agricultural practice.

Some of the chemicals used in agriculture are very toxic. If adequate precautions are not taken, the hazard to the applicator or those in the vicinity may be appreciable. It is essential that the medical practitioner be acquainted with the disease entities and the specific treatment for each of the materials used in the geographical area of his practice. This is no different than knowing what exanthem is prevalent in the area in order to help in diagnosing the disease at the earliest possible time.

The practitioner needs to know that chlorinated hydrocarbon insecticides, such as heptachlor, DDT, dieldrin or toxaphene, can cause loss of appetite, nausea, vomiting, weakness, loss of consciousness and convulsions and that the treatment of choice, once the toxicant has been removed, is barbiturate in large dosage. He should distinguish this syndrome from the cholinesterase inhibition caused by an organic phosphate such as parathion for which the treatment is atropine in dose sufficient to control symptoms.

The many other classes of chemicals used in agriculture may each cause a specific type of intoxication if excessive exposure occurs. The disease entity is as specific as any bacteriologic disease.

I could continue at great length listing various chemicals, the disease pattern they

produce, and the suggested method of treatment. The list is long and growing yearly.[4] I will mention only one additional category of man-made disease, namely the accidental ingestion of medicinals by young children.

Medicinals

One of the largest categories of man-made disease results from children ingesting medications prescribed for themselves or the parents. It should be part of the physician's procedure to constantly warn of this possibility and to urge the parent to keep medicinals out of reach of the children in the house. As almost nothing is out of a child's reach, I suggest a locked medicine cabinet or drawer and the discarding of medicinals that are no longer needed.[5]

Medicine of Future vs. Man-Made Disease

There is a possibility of disease resulting from processes accompanying new technologic developments. In order to know whether or not these new processes or materials result in disease an awareness of epidemiologic techniques is needed, particularly by the medical practitioner who is not a public health officer. The very circumstances of the introduction of a new process make it extremely difficult to be certain of a particular etiologic agent as the causative factor in a disease. In one recent episode, six men were treated for six different diseases by six different physicians. Lack of awareness of the possible role of the man's work in relation to his disease resulted in six different erroneous diagnoses, with six different treatments, none correct.

Cause and effect follow one another in man-made disease as in any other type of disease. Because a man works in a distillery his disease is not necessarily attributable to ethanol. He must actually be exposed to an agent which is capable of causing the disease under investigation. Greater attention to the work and home environment is essential if the correct diagnosis is to be made.

The public health officer must assume a larger share of the responsibility for the prevention and diagnosis of man-made disease. His ability to get to the manufacturing or processing plant and become acquainted with the possible hazards can be of real assistance to the private practitioner in arriving at a diagnosis. Inspection of industrial plants serves as a means of preventing unnecessary hazards by calling them to the attention of management and suggesting corrective measures.

The day is past when industry and its health problems were beyond the purview of the health department. Working together, the private practitioner, the industrial physician and the health officer can diagnose previously undiagnosed "man-made diseases" and prevent their future occurrence. Only by close cooperation of this type can we really solve the problem of the "man-made disease."

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Dysgerminoma

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A case involving an ovarian tumor weighing 12.7 pounds is described. Surgical judgment of the authors was influenced by the age of the patient and preservation of fertility

DYSGERMINOMA, a solid tumor of the ovary, exhibits distinctive histological characteristics but does not exert feminizing or masculinizing tendencies.[5] It is the female equivalent of testicular seminoma. Although this tumor is classified as neuter in secondary sexual changes, about 50 per cent of cases co-exist with the subnormal gonadal development of pseudohermaphroditism. Removal of the tumor has no bearing on these anomalies.[6]

Dysgerminoma constitutes approximately 10 per cent of ovarian malignancies and one per cent of all ovarian tumors.[6] By 1955, one observer was able to collect 540 cases[9] reported in the literature. The tumor occurs in the younger age group, the majority occurring under 30 years of age, but ranging from 5 to 78 years of age.[4, 8] These tumors are bilateral in 15 per cent of cases. When unilateral, the right ovary is more often involved. They may vary from two centimeters to a size filling the abdominal cavity.[6]

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Dysgerminoma is a true malignant tumor, but there is much variation in individual cases. They are definitely less malignant in nature than granulosa cell cancers. Dysgerminomas may involve surrounding organs by extension and distant organs by metastasis. Often the tumor is found well encapsulated in the involved ovary. In those with extension beyond the capsule, there is approximately 40 per cent mortality.

Treatment and prognosis depends upon the extent of the tumor. If unilateral and confined within one ovary, simple oophorectomy may cure most cases and at the same time preserve fertility. Those cases involving both ovaries or extending beyond the capsule have a poor prognosis even with radical surgery.[2, 7, 8, 3] The tumor is extremely radiosensitive[1] and evidence of recurrence or metastasis demands the use of radiation. The five-year survival rate is approximately 30 per cent.

Case Report

The following case is reported for statistical value.

Mrs. M. K. S., a 20-year-old white female gravida I, Para I was first seen by her local physician six months after normal delivery with the chief complaint of amenorrhea. The only other symptom at this time was a mild lower abdominal discomfort. On pelvic examination there was a palpable mass which clinically was thought to be an enlarged uterus. The mass grew rapidly and the patient described an increase in lower abdominal pressure. She had lost some 30 pounds, from 180 to 150, and the abdominal tumor was quite noticeable.

On one occasion, preoperatively, she had signs and symptoms consistent with urinary tract infection.

On examination before entering the hospital, the mass was found to have increased to the size of a term pregnancy. A tentative diagnosis of solid ovarian tumor was made and the patient was prepared for surgery.

Under GOE endotracheal anesthesia and through a lower abdominal incision, the abdominal cavity was explored. A huge, solid, ovarian tumor was encountered. It was confined to the left ovary. The right ovary was normal grossly. There was no evidence of extension to the broad ligament or other contiguous organs. The liver was free of palpable nodules. Further investigation revealed two small lymph nodes of the left peri-aortic group near the left renal artery. These, after removal, were normal grossly and the pathological report was negative for malignancy. The tumor was judged to be well encapsulated and localized in the left ovary, and with preservation of fertility in mind, a left salpingo-oophorectomy was carried out without technical difficulty.

The Pathological Report

Lab. No. C9415-60, Date 1-12-1960. *Gross examination*: The specimen consists of a huge solid tumor from the left ovary of a 20-year-old patient. The tumor is nodulated, with multiple deep crevices entering into its substance. However, it is encapsulated and the capsule is smooth. The structure weighs 5,760 grams and measures 34 x 19 x 10 centimeters. The Fallopian tube is attached. There is an appendix present with the structure. Also, there is a peri-aortic lymph node. The lymph node measures about one and five-tenths by eight-tenths (1.5 x .8) centimeters. Sections of the tumor reveal that it is solid except for some zones of hemorrhage. It presents a tan color.

Miscroscopic examination: Sections show a neoplasm characterized by the presence of cells that are characteristically uniform. They are grouped into nests separated by septa of fibrous connective tissue. The cells tend to be separated by clear spaces and all together present a picture that is textbook in appearance of a dysgerminoma.

In focal areas, there is dense fibrosis and distortion of the nests so that undifferentiated adenocarcinoma has been a differential problem. However, after due consideration I believe the tumor is a malignant dysgerminoma. There are large numbers of mitotic figures. The entire node has been embedded and metastasis is not found. The appendix does not show inflammation.



Figure 1

Dysgerminoma of the left ovary, removed at operation. Note the enormity of tumor which measured 34 x 19 x 10 centimeters and weighed 12.7 pounds.

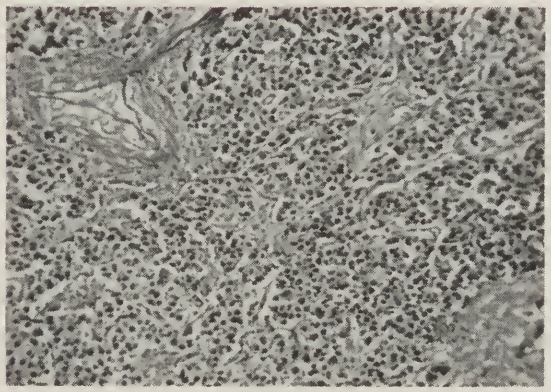


Figure 2

High power photomicrograph of dysgerminoma showing characteristically uniform large cells grouped into nests separated by septa of fibrous tissue.

Pathological diagnosis: (1) Malignant dysgerminoma of left ovary without demonstrable metastasis to the lymph nodes.

The patient had an uneventful post-operative course. Follow-up visits by the operating surgeon six weeks after surgery revealed a normal pelvis. The right ovary was palpable and of normal size. The patient had gained

some 15 pounds since discharge from the hospital and had no subjective complaints.

Summary

(1) A large dysgerminoma of the ovary, weighing 12.7 pounds is described. To our knowledge this is the second greatest size so far reported. One author[3] reported one weighing 14.5 pounds in a patient 14 years of age.

(2) The microscopic structure of the tumor revealed a typical dysgerminoma. It was hormonally inactive and presented very few signs or symptoms despite its size.

(3) Since the tumor was well encapsulated and apparently confined to one ovary and without evidence of spread, a unilateral salpingo-oophorectomy was done. The age of the patient and preservation of fertility also influenced our surgical judgment.

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Manuscript Memos

Manuscripts should be submitted in duplicate to The Journal of KSMA, an original copy and one carbon, and typed with double spacing. Maximum length of an article should not exceed 4500 words; the Board of Consultants on Scientific Articles prefers that they be briefer than this when possible.

In submitting a manuscript, the author is requested to include a concise summary, not to exceed 35 words, to be used as a sub-title when the article is published in The Journal. The purpose of the summary is to create additional interest and encourage greater readership.

Footnotes and bibliographies should conform to the style of the Quarterly Cumulative Index Medicus published by the American Medical Association. This requires in the order given: name of author, title of article, name of periodical, with volume, page, month—day of month if weekly—and year. The Journal of the KSMA does not assume responsibility for the accuracy of references used with scientific articles.

All scientific material appearing in The Journal is reviewed by the Board of Consultants on Scientific Articles. The editors may use up to six illustrations, with the essayist bearing the cost of all over three one-column halftones.

Arrangements for reprints of an article should be made directly with the publisher of The Journal, Gibbs-Inman Printing Company, 817 W. Market St., Louisville, Ky.

The bylaws of the Kentucky State Medical Association provide that all scientific discussions and papers read before the KSMA Annual Meeting shall be referred to the KSMA Journal for consideration for publication. The bylaws further state that the editor or the associate editor may accept or reject these papers as it appears advisable and return them to the author if not considered suitable for publication.

Please mail your scientific articles to The Journal of the Kentucky State Medical Association, 1169 Eastern Parkway, Louisville 17, Kentucky.

CASE DISCUSSIONS
From The
University of Louisville Hospitals

Louisville General Hospital

Postoperative Confusion In An Elderly Patient With Sigmoid Volvulus

William J. Hockaday, M.D.*

Case Report

THE patient, a 65-year-old white male, was admitted to the Louisville General Hospital as an emergency on November 25, 1960, with chief complaints of severe, cramping, intermittent pain in the left lower abdomen, and vomiting. Thirty-six hours prior to admission, as he was finishing supper, he became nauscated and vomited repeatedly. An hour later the pain began and became progressively more severe and more frequent. There was neither bowel movement nor flatus following the onset of his prcsent illness, although his usual bowel habit was one movement daily without use of cathartics.

He had never had any major illness or surgery. He did not smoke, but drank to excess, and had worked intermittently as a laborer. During the past year he had increasing loss of memory for recent events which had not interfered with his usual activities and had not necessitated supervision by others.

He was in obvious acute distress and was dehydrated and mildly confused, being unable to give the date though he knew the month, year and day of the week. Blood pressure was 160/80, pulse 90, respiration 20, rectal temperature 99. There was moderate generalized abdominal distension, most evidcnt in the left lower quadrant, and diminished bowel sounds. There was no tenderness.

A barium enema revealed "beaking" of the leading portion of the barium column and converging rugal folds, together with marked distension of the sigmoid colon. Pertinent laboratory studies were: WBC 9,000 (76% Polys); Hgb 13.6 gm%; Hematocrit 40; BUN 27.5 mgm%; Chloride 102 Meq/L; CO2 content 28 Meq/L (normal for laboratory 22-26).

The duration of the obstruction and the physical findings indicated an extracellular fluid deficit and a mild anemia, despite the normal value of the hematocrit. After replacement of blood volume, fluids and electrolytes, an abdominal laparotomy confirmed the diagnosis of volvulus of the sigmoid colon and it was reduced.

The immediate postoperative course was uneventful, but within 24 hours signs of obstruction reappeared despite intestinal intubation, and a second laparotomy revealed obstruction due to adynamic ileus. An obstructive resection of the sigmoid colon was done, and a Miller-Abbott tube inserted. Appropriate replacement of blood, fluid and electrolytes was instituted, and laboratory values of chlorides, potassium, sodium, carbon dioxide content, urea nitrogen and blood volume were maintained within normal limits.

The patient, however, despite his normal laboratory, x-ray and physical findings, demonstrated an obvious downhill course. He became completely disoriented and had to be restrained

*Assistant Professor of Psychiatry and Associate in Surgery, University of Louisville School of Medicine; Daland Fellow of the American Philosophical Society.

to prevent his removing the intestinal tube and Foley catheter. His speech was disjointed, though not dysphasic or dysarthric, and he did not know day from night. *Despite his confusion he continued to relate an accurate history of his present illness.* Efforts to ambulate him were of little avail. Only brief effort to discharge him for care at home (in familiar surroundings) was made, for his relatives were fearful of taking the responsibility.

On the tenth hospital day he again developed signs of incomplete obstruction and these were only partially relieved by intubation. Ten days later another laparotomy revealed an internal hernia, which was reduced. Again, the obstructive signs were relieved, but the confusion and resultant lack of cooperation continued. Efforts to institute self feeding were to no avail and tube feeding was utilized. Ambulation in a chair at the bedside was only briefly and irregularly possible.

On the forty-third hospital day he became extremely restless and agitated, and was given 25 mgm of chlorpromazine intramuscularly. His blood pressure then dropped from 140/80 to 64/40 and he became deeply stuporous, responding only slightly to painful stimulation. There was an associated picture of decerebrate rigidity. The lumbar puncture revealed nothing abnormal. This picture persisted and five days later he expired. His physicians were unable to obtain permission for postmortem examination.

Discussion

This case report illustrates several principles of fundamental significance to good clinical judgment in general, and the discussion is not one of specifically surgical principles. The following facts stand out: that there is no such thing as a "poor" historian, just as there is no such thing as a "good" patient or a "bad" one; that the acutely ill elderly patient may die more as a result of being in a strange environment than as a result of any measurable fluid imbalance or detectable infection; that phenothiazine derivatives are commonly misused as convenient and safe sedatives, when they are in fact potent antipsychotics which require care in handling; and last, but not least, the fact that there are times when the "heroic" approach to operative intervention is of lifesaving significance to the patient, and when conversely, if one temporizes, one will have no second chance to do so again.

Patients will usually offer information which is more pertinent to their illness than that obtained from any other source. That physician who says that his patient gives a "poor" history often implies that he is himself a poor observer. Patients give levels of information—some higher, some lower, and some more direct, others more indirect. Some complain bitterly of a pain, later found to be due to a conversion mechanism. Such patients find that mild side effects of a drug to relieve it are worse than the "severe" pain. That they are not to be condemned for a deliberate exaggeration is obvious. Others may primarily need sympathy, or an excuse for getting away from home or work, or punishment in the form of surgery for some fancied guilt—their history will be accordingly obfuscating to the physician, and the felony may be compounded because they've told the story so often they can't tell it the same way each time.

Clearing Up the Confusion

The patient presented herein gave the best obtainable account of his present illness, even late in his illness when otherwise totally disoriented and critically ill. When one feels confused about the interpretation of a history, then one must find out specifically why.

Elderly patients with acute (less often, chronic) disorders often develop pre or postoperative confusion. This commonly occurs without demonstrable fluid or electrolyte imbalance, infection or focal brain lesion. There are personality factors importantly involved: operations on certain specific organs are more likely to produce confusion than those upon others; the quality of the symptomatology reflects the pre-illness personality of the patient; and the vigorous, outgoing and active type of individual is much less likely to develop such symptoms than is any other sort of person.

The presence of a close relative at the bedside and the establishment of rapport with the patient by the anesthesiologist well in advance of the operation will go far toward the prevention of postoperative confusion. This may take a good bit more time and effort in the elderly patient than in the younger one, but it is well worth the effort for it may well be lifesaving. Other helpful preventive measures include placing the patient near a bath-

room and keeping a night light turned on to prevent getting lost, suggesting that a familiar piece of bedroom furniture (bureau or chest) be brought along at the time of admission, and avoiding the use of barbiturates, especially the long-acting ones.

The onset of confusion is often recognized by neither nurse nor doctor, yet it is at this time that it may be most readily treated. At the onset, confusion usually appears only at night, fluctuates in severity from hour to hour, and may be so subtle as to result, for example, in only the forgetting of a name or two. Such patients commonly wander down the hospital corridor, and may give the nurse a logical answer when asked where they are going.

It is at this stage of confusion that discharge from the hospital to go home to familiar surroundings will usually restore the sensorium to its normal. (It is assumed that clinical and laboratory findings have ruled out blood volume and electrolyte abnormalities, as well as infection and focal neurologic disorders.) Even profound confusion may respond to the same treatment, and efforts to send this patient home were made, but his relatives felt that he might die, (which was quite likely, indeed), and were fearful of taking the responsibility despite assurance of visiting nursing care.

This patient's volvulus was initially reduced without further surgery in an effort to shorten the procedure because of his advanced (physiological) age and poor condition. Had a more definitive procedure been done; that is, some form of resection and anastomosis — even though this would have been "heroic" surgery, it might have been better than the predictable outcome otherwise. This patient, with his poor nutritional state, history of memory loss and advanced age, presents a picture which warrants a strong prediction of postoperative confusion and its accompanying downhill course.

The significance of the hypotensive reaction to this patient's demise is probably no more than coincidental, for the ultimate outcome was inevitable. It serves here to dramatize, however, the potency of chlorpromazine. Those who doubt this example of its potency will do so only because they have not observed such reactions to it, for they are not frequent. Good drugs are potent drugs, and their use should be with respect and practice; giving an occasional potent drug is not unlike doing an occasional difficult surgical procedure.

In addition, chlorpromazine is not properly used as a sedative, for it is an antipsychotic drug. It is occasionally quite useful in the senile, but there are any number of safer sedatives for temporary use at bedtime and for the acutely confused elderly patient.



SPECIAL ARTICLES

Medical Center Dedication Address

GOVERNOR BERT T. COMBS*

IT has been said that Kentucky can't afford this Center. I say we can afford it. Actually, Kentucky cannot afford to be without this Center.

While I had nothing to do with starting the project, and claim no credit for it, I approve of it 100 per cent and will do everything in my power to make it a complete success.

Many people are entitled to credit for the inception and building of this great monument to medical progress in Kentucky. Among them are Lawrence W. Wetherby, Dr. H. L. Donovan and the members of the University's Board of of Trustees in 1954.

Also on the list are Dr. John S. Chambers and Russell White. Probably highest on the list is former Governor Albert B. Chandler, whose vision and perseverance constituted the driving force for transforming a wonderful dream into a wonderful reality. You, Governor Chandler, ought to be proud, and certainly the people of Kentucky are grateful to you.

There are others who deserve great credit: The members of the General Assembly who recognized the need for a medical center and appropriated the necessary funds; the members of the medical, dental and nursing professions who campaigned for the project; the University's Trustees, and certainly President Dickey, Dean Willard and their associates, who wrought wonders with the tools placed in their hands.

To all of them I express the appreciation of the people of Kentucky.

This Center is an expression of faith in Kentucky's future.

This branch of the university starts out with a ready-made tradition. No one here needs to be reminded of this State's prestige in the field of medicine. Doctor McDowell has been followed by many other brilliant Kentucky stars in the medical sky. The University of Louisville's Medical School ranks very near the top in the nation.

Vast Potential

This new Medical Center has a vast potential for long-range contribution to total health services for all Kentuckians. Although it has the primary responsibility to train professional workers, it also has the opportunity and, I believe, the responsibility to improve health services throughout the Commonwealth.

Realizing this potential of better health for every citizen requires much more than simply providing more doctors, dentists and nurses. In keeping with one of the functions of a university, this realization demands anticipation of the future development of new ideas and methods, and challenging the status quo when necessary.

Because research is a highly important phase of medical education, adequate space and equipment for research is being provided for in the Medical Center. I am happy to learn that more than $500,000 in research grants already have been awarded to faculty members.

The Center must study not only health needs

Address delivered at the University of Kentucky Medical Center dedication ceremonies in Lexington, Kentucky, on Friday, September 23, 1960.

of Kentucky people; it must determine the kind of medical environment necessary to attract medical personnel, and must study the difficulties incidental to providing high quality medical treatment to sparse populations.

When one realizes that this year's class can begin practice in 1966 at the earliest—some who obtain specialty training and go into military service, not until later—and when it is considered that these young people are being prepared for a professional life of 30 to 40 years, it can be seen why the Medical Center must prepare for tomorrow as well as today.

In a few years, though, the Center will be in full operation. Approximately 300 medical, 200 dental and a minimum of 250 nursing students will be on campus. In addition, interns, residents and students enrolled in technical training such as dental hygiene, laboratory technology and the like will bring the student total to between 1,100 and 1,300. These figures do not include the physicians, nurses, dentists and other health workers who will attend postgraduate courses, institutes and conferences.

Adjunct to State Programs

Thus, the long-range potential of the University of Kentucky Medical Center is truly great. It will make its contribution to the future of Kentucky in increased numbers of doctors, nurses, dentists and other health personnel which are so vitally needed.

This new Medical Center also is an important adjunct to the expanded programs which the State government has undertaken to improve the health and welfare of Kentuckians. You are aware, of course, of the substantial increase which the General Assembly has made in appropriations for the Department of Public Health, Mental Health, the Tuberculosis Commission, Crippled Children's Commission and for similar programs.

All these programs stand to benefit from the research and the knowledge imparted by the Medical Center.

The Medical Center also will provide educational opportunity for Kentucky youth in many health fields. This, however, means a quality of student, which is in turn dependent upon public-school education. In order to provide more students with the intelligence and incentive to qualify for these opportunities, we must make over-all improvements in education.

The people of Kentucky are willing, I believe, to provide salaries, environment and program monies which will allow the Center to engage the best in personnel and to provide the best in service.

Sparkle of Things to Come

Most of the students who attend this school will be from Kentucky. I hope that most of them will practice their profession here in Kentucky. We need them badly. I also hope that the rural medical scholarship fund will be utilized to the utmost so that our more sparsely settled sections will benefit. If things work out as we hope, rural medical practice will be radically different from what it has been in the past. Kentucky people will have higher incomes. They will be better able to afford good medical care. Many of those who cannot afford it will be cared for under the medical aid plan recently enacted by the Federal Congress and the Legislature of Kentucky.

Fit this wonderful Center into Kentucky's over-all educational picture and you begin to see the sparkle of things to come. Our public and private schools and colleges are expanding and upgrading all over the State. New branches of the university are planned.

The years ahead of us can be years of enlightenment and progress. From mediocrity in many fields, we are rising toward the heights of achievement. Kentucky has geared its thinking to the age of space.

If each of its stages of progress is as beautifully conceived and as competently put together as this Medical Center, our place in the sun is assured.



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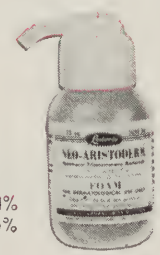
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The anti-inflammatory and antipruritic efficacy of triamcinolone acetonide was shown by the prompt control of itching and resolution of affected areas. Cahn, M. M., and Levy, E. J.: A Comparison of Topical Corticosteroids: Triamcinolone Acetonide, Prednisolone, Fluoromethalone, and Hydrocortisone.

Antibiotic Med. & Clin. Ther. 6:734 [Dec.] 1959.

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EDITORIALS

He Also Serves

A COLLEAGUE recently remarked that the quality of medicine practiced could not be accurately judged by the physical appearance of the doctor or his office—that he was often surprised by the thoroughness and effectiveness of diagnostic study and treatment by physicians who were the least pretentious. Conversely, the quality of medical care coming from some well appointed and staffed establishments is sometimes disappointing.

If you would meet the man in medicine today who is most widely known and best beloved, you may seek in vain for him in the towering health institutes of our government, in the chairs of highest learning and postgraduate training, or in any of our magnificent research facilities. He would most likely be found in a remote and primitive African village. He would be reading or working by lamp or candle light. No electricity would be found in his village except that provided by the crude generator used only for surgical operations. You would find him at menial and lowly tasks whenever necessary to keep his establishment in operation. He would be questioning the patient individually and examining him with his own hands in an office or clinic equipped with the most meager necessities. He would be an 86-year-old physician who has labored for more than forty years in structures largely built and equipped by his own individual efforts; and his name would be Dr. Albert Schweitzer.

Dr. Gordon S. Seagrave, Dr. Tom Dooley, and a multitude of other physicians have devoted their lives to service in areas of the earth that have generally been deemed of little importance and among people who have not attained status in the present world of culture and progress. The ministry of these men of medicine and faith, who have served in the faraway and isolated countries of the world, has been perhaps far more important in the events of the last half century than we have believed. During World War II it was felt that our armed forces were received with kindness and welcome and gratitude among peoples who were foreign to us except for the contact with our missionaries during the preceding decades.

These men who have carried healing to the remote corners of the earth have exemplified medicine at its best. They have taken the findings of experience, of experimentation and research, and necessarily with the simplest of equipment and devices have administered to the physical needs of their people in an extraordinarily efficient and helpful manner.

Our modern concepts of medicine tend to glorify physical equipment, research, higher postgraduate training and experimentation and to neglect the practitioner whose art it is to acquaint himself with the best products of research and the experience of others and to apply them directly to the relief of the suffering of the individual in that environment in which he finds him. After all, this is the flower and the fruit of our profession. Medicine today is a vast and complex machine, but the cutting edge is the application of scientific findings to the relief of suffering and the healing of individuals.

We would not underestimate the importance of research nor detract one bit of the glory from the memory of those who have devoted their lives in the long and sometimes futile quest

for new modalities for the eure of disease. Madame Curie handled tons of piteh blend in her seareh for radium and died a vietim of eancer, the direet result of her seareh for this element whieh has been a healing measure to multitudes of suffers around the world; and she is but one of thousands of physieians who have lived and worked as pure scientists. Our present thesis, however, is that the man who learns and applies the results of researeh to individuals in his daily routine is actually the unsung hero in medieine.

We are delighted that fine hospitals equipped with the most reeent seientifie apparatus and staffed by men who have learned its proper use in the study and treatment of disease have eome to the people of Eastern Kentueky. We would not underestimate the value of these establishments in potentially improving the well being and raising the health standards of our people. We do dispute, however, the oft repeated assertion that the praetiee of medicine in this area was deplorable before these hospitals were established. It has not been neeessary for the suceess of the present enterprise that the preceding medical praetiees in that area should be so eontemptuously disparaged.

The three seourges of disease—traeoma, pellegra and hookworm—so destructive of health two generations ago had all but been eradicated from Eastern Kentucky twenty years ago. Cooperation of Public Health and private physicians had accomplished this before the present fine hospitals and their well trained staffs came upon the seene.

Dr. Milus Gunn, Dr. Clark Bailey, and his illustrious father who preceded him, and their colleagues gave to Harlan County a very high standard of medical practiee long before the present era. Dr. Edward Wilson and his eolleagues in Pineville, Drs. Logan and Tye in Barbourville, Dr. Paul Gronnerud in Pikeville, Dr. A. J. Davidson in Prestonsburg, Drs. J. H. Holbrook and E. E. Areher in Paintsville, and Dr. S. B. Snyder in Hazard are but a few of distinguished physicians and surgeons who gave to Eastern Kentueky exeellent medieal eare a generation and more ago. These men, with their own resources, established and operated creditable hospitals whieh were approved and effective by the standard of their day.

A great number of younger men just out of medieal sehool and internship began their praetiee in the mining eamps of Eastern Kentueky and rendered skillful serviee to their people. Many of these, after a few years of praetice, did postgraduate training and have beeome leading speeialists in the cities of the East, Midwest and South. Others, equally capable, remained there or returned after postgraduate training and have maintained a very high standard of praetice throughout the area.

In the present enthusiasm over modernization, we would do well not to regard with eontempt the efforts and aeeomplishments of our immediate predecessors who in their time perhaps rendered a more effeetive and aeeeptable serviee than we do today. St. Joseph Infirmary on Fourth Street, the old Jewish and Deaeoness hospitals were no great shakes by our present-day standards, but they served the past generation exceedingly well, and the physicians and surgeons who worked in them maintained as high seientifie and ethieal levels as are praetieed today. The same ean be said of the hospitals and physieians of yesterday in the other areas of our State.

It is well that we should devote greater energy, better teaehing, and more widespread postgraduate study, and more intensive researeh to the eause and eure of disease. We should not forget, however, that the application of these findings to the individual subject and the relief of pain and the eure of disease where it is found is, after all, the finished and prized product of our profession. It is to the vast number of physieians here and in the remote areas of the earth who perform this service that we here pay a simple tribute.

Sam A. Overstreet, M.D.

Be Informed

WE have reason to be proud of the performance of Blue Shield and Blue Cross in Kentucky during the past decade. Our organization has attained a unique distinction because it has consistently maintained a very close liaison with the medical profession and the hospital organization. It seems highly desirable that this friendly relationship and cooperation should continue.

The operating staff of the Physicians Mutual and Blue Shield has made an honest effort to reflect the policies of the physician members of the board, and of the advisory council. It has attempted to give the best service to hospitals and to extend its benefits to all of the hospitals within the state that are prepared to cooperate. Field workers are constantly in circulation throughout the state visiting hospital directors and physicians in order to acquaint themselves with the criticisms or suggestions of as many concerned individuals as possible.

The Board of Directors of Kentucky Physicians Mutual has repeatedly expressed a willingness and desire to have a reliable representative of their staff visit any county society or district meetings of the KSMA as often as they may desire to have them. It is felt that at least one meeting a year for each county society or district should be devoted to an informative talk or question-and-answer session by a member of the operating staff.

Particularly in the present period, we as physicians must keep as well informed as possible on the problems and issues involving Blue Cross and Blue Shield. It is urged that each society avail itself of this opportunity at least once or twice during the year.

Sam A. Overstreet, M.D.

For Those Who Plan Ahead . . .

AMA Annual Meeting — June 26-30
New York City

KSMA Annual Meeting — Sept. 19-21
Columbia Auditorium, Louisville, Ky.

AMA Clinical Meeting — Nov. 28-Dec. 1
Denver, Colo.

ORGANIZATION SECTION

KIMA Joins the Specialty Groups Cooperating In Annual Meeting

A new specialty group will cooperate in the 1961 Annual Meeting of KSMA in Louisville, September 19-21, it is announced by KSMA President Richard G. Elliott, M.D., Lexington.



Dr. Princi

Approval by the Board of Trustees of the Kentucky Industrial Medicine Association's application to participate in the scientific program brings to 14 the number of cosponsoring organizations.

The KIMA has been assigned Thursday morning, September 21, for its scientific meeting, according to Eugene H. Kremer, M.D., Louisville, president. Its guest speaker will be Frank Princi, M.D., associate director of the Kettering Laboratory and professor of industrial medicine at the College of Medicine of the University of Cincinnati.

A 1941 graduate of the University of Colorado School of Medicine, Doctor Princi later served the school as associate professor of medicine and as director of the Division of Industrial Medicine at the Medical Center. He is a Diplomate of the American Board of Preventive Medicine and a member of numerous medical groups.

Plans are well under way for the entire scientific program of the Annual Meeting, announces Frank M. Gaines, Jr., M.D., Louisville, chairman of the KSMA Scientific Program Committee.

Film Exhibit On AMA Program

The second U. S. International Medical Film Exhibition will be a special scientific feature at the 110th annual meeting of the American Medical Association in New York City, June 25-30. Some 50 medical films, including more than 30 from foreign countries, are being coordinated by the AMA Department of Medical Motion Pictures and Television in cooperation with Johnson and Johnson for showing in New York's big Coliseum during the convention.

"The American Medical Association is happy to present these outstanding films to its members," F. J. L. Blasingame, M.D., executive vice-president, announced in Chicago.

No Charge, Doctor!

You received on March 15 a copy of the AMA booklet entitled "The ? Cost of Medical Care." The covering letter indicated that the price of these booklets, designed to assist in the explanation of the cost of medical care to your patients, was quoted as being five cents per copy.

The AMA is now glad to announce free distribution of this very helpful material. If you would like to have additional copies or if you have not sent for your supply, please write the KSMA headquarters office, 1169 Eastern Parkway, Louisville 17, and a supply will be sent to you.

At press time, a large number of orders with accompanying checks had been received. We thank these members for their interest and are returning their remittances.

Physicians Urged to Participate In Immunization Week May 7-13

Immunization Week, May 7-13, has been made official in Kentucky by proclamation of the Governor, and the KSMA Committee on Public Health and Prevention of Highway Accidents has completed plans for its observance.

The participation of all KSMA members is urged by Committee Chairman, Delmas M. Clardy, M.D., Hopkinsville. Each physician can help, he said, by checking the immunization status of his patients and by displaying the special posters mailed from the KSMA Headquarters Office.

The importance of the special week was pointed up by recent action of the State Board of Health calling for a vigorous immunization program to meet the increased incidence of polio in Kentucky. In 1960, there were 165 cases reported—an increase of 52 cases or 31.5 per cent over the preceding year. Other diseases against which immunization is provided are diphtheria, pertussis, tetanus, smallpox and typhoid.

Working with the KSMA in this annual drive are several organizations, including the Woman's Auxiliary to KSMA, parent-teacher associations, home demonstration agents, homemaker clubs and the Kentucky Federation of Women's Clubs.

U. of K. Approves Student AMA

A petition to form a University of Kentucky Chapter of the Student American Medical Association has been approved by the university. Faculty advisers for the new organization are Dr. Michael Wilson, physiology, and Dr. Jesse Harris, psychiatry.

Surgical Society Announces French Lick Program

The Kentucky Surgical Society will hear 28 essayists in discussions of 16 papers at its annual meeting Saturday, May 13, in French Lick, Ind., according to the program released by Rudolf J. Noer, M.D., chairman. The Surgery Department of the University of Louisville School of Medicine, of which Doctor Noer is professor and chairman, will put on the scientific presentation.

A meeting of the Council is scheduled for Friday night, May 12, and the annual business meeting of the



Dr. Hancock



Dr. Noer

society will be held at 4:30 p.m. Saturday, announces C. Melvin Bernhard, M.D., Louisville, secretary-treasurer.

The program will be concluded with a cocktail party and banquet Saturday evening, featuring Prof. Kenny Melton, Chicago, directing "McNamara's Band." The society's president, J. Duffy Hancock, M.D., Louisville, will preside.

The complete scientific program follows:

Morning Session

Rudolf J. Noer, M.D., presiding

"Bladder Base Resection for Recurrent Cancer of the Cervix—Condict Moore, M.D., Douglas M. Haynes, M.D., and L. Douglas Atherton, M.D.

"Dupuytren's Contracture: Operative Management"—Harold E. Kleinert, M.D.

"Corneal Homografts"—Mahabir Jain, M.D., and Roderick Macdonald, M.D.

"Experimental Single Layer Esophageal Anastomosis"—Joseph Kutz, M.D., and Hugh B. Lynn, M.D.

"Mechanical Pulmonary Ventilators In the Treatment of Thoracic Trauma"—Herbert T. Ransdell, Jr., M.D., and Eugene H. Conner, M.D.

"Postoperative Delirium"—William J. Hockaday, Jr., M.D.

"Penetrating Injuries of the Subclavian Artery"—Frank Cook, M.D., and J. Alex Haller, Jr., M.D.

"Use of Hypothermia In Head Injury"—Joseph Keith, M.D., Everett G. Grantham, M.D., and Ludwig H. Segerberg, M.D.

"The Immediate Care of Maxillofacial Injuries"—Robert G. Cooper, M.D.

Afternoon Session

James C. Drye, M.D., presiding

"Voiding Vesical Uretheography"—Robert Lich, Jr., M.D., and Lonnie Howerton, Jr., M.D.

"Limb Salvage Through Small Vessel Surgery"—Alvin B. Ortner, M.D., Harold F. Berg, M.D., and Alvin Lebendiger, M.D.

"Severe Lower G. I. Hemorrhage—Diagnosis and Treatment"—Donald J. Williams, M.D., and Rudolf J. Noer, M.D.

"Hydrostatic Pressure Therapy In Experimental Burns"—John J. Wolfe, M.D.

"Management of Ocular Infection"—Roderick Macdonald, M.D.

"Congestive Atelectasis: Experimental Studies"—James C. Drye, M.D., Eugene H. Conner, M.D., and Norton Waterman, M.D.

"Morbidity and Mortality Related to Duration of Anesthesia"—Eugene H. Conner, M.D., and Donald M. Thomas, M.D.

Ohio Valley Plastic Surgeons Meet In Louisville May 4-7

The Ohio Valley Plastic Surgery Society has chosen Louisville, the home city of its president, John C. Weeter, M. D., as the site for its annual meeting May 4 through 7. Headquarters will be the Sheraton Watterson Hotel.

A distinguished guest will be Jack Penn, M. D., plastic surgeon from Johannesburg, South Africa. Sponsored by the American Cancer Society, he will speak on "Reconstructive Surgery and Facial Cancer."

Clyde Litton, M. D., Charleston, West Va., the society's president-elect, will be installed as president at the meeting. John Tondra, M. D., Indianapolis, is secretary of the group which has some 60 members in Kentucky, West Virginia, Indiana, Ohio and western Pennsylvania. About 35 members and their wives are expected at the Louisville meeting.

Dr. Haller Gets Two Research Grants Totaling $60,000

Two $30,000 research grants were awarded within a month to J. Alex Haller, Jr., M.D., who recently was promoted from instructor to assistant professor of surgery at the University of Louisville School of Medicine. One came from the John and Mary R. Markle Foundation of New York and the other from the National Heart Institute, a division of the U. S. Department of Health, Education and Welfare.

Doctor Haller is one of 25 young faculty members of medical schools who were appointed Markle Scholars in Medical Science to receive $30,000, at the rate of $6,000 for the next five years, toward their support and research.

The $30,000 heart-research grant is for three years and will be used by Doctor Haller to develop an artificial valve for the human heart.

Announcement has also been made of a $1,500 grant to the U. of L. School of Medicine Open Heart Surgical Fund by the WHAS Crusade for Children. The grant was requested by Doctor Haller.

14th District Ready For Meeting At Paintsville April 19

Three essayists will present the afternoon program for the annual meeting of the 14th Trustee District at the Paintsville Country Club on Wednesday, April 19, it is announced by William C. Hambley, M.D., Pikeville, trustee.

KSMA President Richard G. Elliott, M.D., Lexington, will be the featured speaker at the evening session following a social hour and dinner.

The scientific program will be opened at 3 p. m. by a panel composed of two faculty members of the University of Louisville School of Medicine—Alvin B. Ortner, M.D., professor of surgery, and F. Albert Olash, M.D., instructor in medicine. They will discuss "Arterial Thrombosis." Guest speaker will be Jack Crowell, Ph.D., associate professor of the Department of Physiology and Biophysics at the University of Mississippi School of Medicine, talking on "Anticoagulants."

Ernest Skaggs, M.D., Paintsville, president of the Johnson County Medical Society, will preside at the afternoon meeting and Doctor Hambley at the evening session.

Physicians from the district's nine counties—Breathitt, Knott, Johnson, Floyd, Magoffin, Martin, Perry, Letcher and Pike—are expected to attend. Wives of the physicians are invited.

Plans Complete For 13th District Meet At Ashland April 20

Physicians from eight counties and their wives have been sent invitations to attend the annual meeting of the 13th Trustee District at the Henry Clay Hotel in Ashland on Thursday, April 20. The program, announced by Charles B. Johnson, M.D., Russell, trustee of the district, will feature papers by three medical specialists and an address by KSMA President Richard G. Elliott, M.D., Lexington.

Host for the meeting will be the Boyd County Medical Society headed by Guy Cunningham, M.D., Ashland.

Essayists for the scientific session starting at 2 p. m. (EST) will be: Wallace E. Herrell, M.D., Lexington, speaking on "Erythrocillin In Management of Infections Due to Antibiotics—Resistant Staphylococci"; Eldon R. Dykes, M.D., associate in plastic surgery, Cleveland Clinic, "Fluid and Electrolyte Balance," and Rudolf J. Noer, M.D., professor and chairman of the Department of Surgery, University of Louisville School of Medicine, "Massive Rectal Bleeding: Diagnosis and Treatment."

A social hour at 5:30 p. m. will be followed by a dinner with Doctor Elliott as the speaker.

The eight counties in the 13th District are Boyd, Carter, Elliott, Greenup, Lawrence, Lewis, Morgan and Rowan.

St. Louis Professor to Address 11th District April 27

J. Neal Middelkamp, M. D., assistant professor of pediatrics at Washington University School of Medicine, and KSMA President Richard G. Elliott, M. D., Lexington, will share the spotlight as featured essayist and speaker at the 11th Trustee District meeting at the Richmond Country Club on Thursday, April 27.

The program will follow a social hour at 5:30 p.m. and dinner at 6:30, according to Hubert C. Jones, M. D., Berea, trustee of the 10-county district. Wives of physicians are invited.

A 1948 graduate of Washington University School of Medicine, Doctor Middelkamp now holds two positions at the St. Louis school. In addition to his post in the Department of Pediatrics, he is visiting assistant professor of the Division of Infectious Diseases, Department of Internal Medicine. He will speak in Richmond on "Meningitis In Infants and Children—Bacterial and Viral."

The meeting is expected to draw physicians from Clark, Estill, Jackson, Lee, Madison, Menifee, Montgomery, Owsley, Powell and Wolfe Counties.

First District to Meet May 25

The First Trustee District will meet Thursday evening, May 25, at Kenlake Hotel, Hardin, according to Hugh L. Houston, M. D., Murray, trustee. KSMA President Richard G. Elliott, M. D., Lexington, will speak and a scientific program will be presented.

Wives of physicians are invited to the meeting which will open with a social hour at 6 p.m., followed by a dinner. Full details will appear in the May issue of The Journal of KSMA.

Second and Third Pick May 26

The Second and Third Trustee Districts will hold a joint evening dinner meeting on Friday, May 26, at the Henderson Country Club, Henderson. The announcement was made jointly by Walter L. O'Nan, M.D., Henderson, and Ralph D. Lynn, M.D., Elkton, trustees of the Second and Third Districts, respectively. Program details will be announced in the May issue of The Journal.

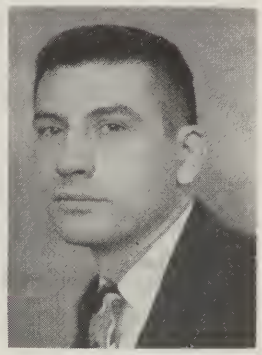
12th and 15th to Meet June 1

A joint meeting of the 12th and 15th Trustee Districts of KSMA is planned for June 1 at Cumberland Falls.

Thomas O. Meredith, M.D., Harrodsburg, and Keith P. Smith, M.D., Corbin, respective chairman of the two districts, will make an announcement of the program in the next issue of The Journal.

Ob-Gyn Society Set for May Meeting In Cincinnati

The Kentucky Obstetrical and Gynecological Society has completed the program for its 14th annual meeting, May 18-20, at the Netherland Hilton Hotel in Cincinnati.



Dr. Cleveland

Guest speaker will be Frank P. Cleveland, M.D., Cincinnati, who was a participant in the 1959 Annual Meeting of KSMA. He will present a paper Friday afternoon, May 19, and address a meeting of the Kentucky Maternal Mortality Committee Saturday morning, May 20.

Doctor Cleveland holds two positions at the University of Cincinnati College of Medicine—associate professor of industrial health, Department of Preventive Medicine and Industrial Health, and director of research, the Kettering Laboratory. He also is associate professor of forensic pathology of the Department of Pathology, Cincinnati General Hospital. Two of his scientific papers were published by The Journal of KSMA in 1960.

May 18

A meeting of the executive committee will open the meeting Thursday morning, May 18, according to the program announced by John H. Siehl, M.D., Covington, president of the society.

The scientific session Thursday afternoon will include:

"Treatment of Threatened Abortion With Progesterone"—Robert W. O'Conner, M.D., Newport.

"Treatment of Eclampsia"—Joseph F. Daugherty, M.D., Florence.

Panel Discussion—Doctor Siehl, moderator; Laman A. Gray, M.D., and Douglas M. Haynes, M.D., Louisville; George G. Greene, M.D., Lexington, and Robert E. Johnstone, M.D., Cincinnati.

May 19

Presentation of the winning Ob-Gyn Resident Paper is planned for Friday morning, followed by a scientific program: "Treatment of Side Symptoms of Pregnancy" by Clinton Lacy, M.D., Owensboro, and "Malpractice In Relation to Ob-Gyn" by Riley Lassiter, Louisivlle.

Doctor Cleveland will speak in the afternoon on "Forensic Medicine As Applied to Ob-Gyn."

May 20

The meeting of the Kentucky Maternal Mortality Committee Saturday morning, with William H. Parker, M.D., Owensboro, as chairman will conclude the conference.

Dr. Pierce Named to Commission For Promoting Health Plans

W. Vinson Pierce, M.D., Covington, has been appointed a member of the recently-organized Joint Commission for the Promotion of Voluntary Non-Profit Prepayment Health Plans.



Dr. Pierce

A member of the American Medical Association Insurance Committee, he is one of three AMA representatives on the commission, which also includes three members each from the American Hospital Association, the Blue Cross Association and the National Association of Blue Shield Plans.

The Commission was created as a result of action taken by the AMA House of Delegates at its meeting in Washington, D.C., November 28-30, 1960, when it adopted the report of the Reference Committee on Insurance and Medical Service. Included was the following resolution:

"Resolved, That the House of Delegates direct the Board of Trustees and the Council on Medical Service to assume immediately the leadership in consolidating the efforts of the American Medical Association with those of the National Association of Blue Shield Plans, the American Hospital Association and the Blue Cross Association into maximum development of the voluntary non-profit prepayment concept to provide health care for the American people."

"The commission has no power to commit any of the member organizations to any action of the body," Doctor Pierce pointed out. "The recommendations reached jointly by the membership of the commission will be taken to each of the constituent organizations, and be considered independently by these organizations. It is hoped that through this mechanism closer cooperation and more effective action on the part of each of the four groups will eventuate."

Reporting on a meeting between representatives of the private carriers and the AMA on March 5, Doctor Pierce said, "No actions were taken, but discussions of policies, objectives and areas of common interest led to a feeling on the part of those present that continued and improved cooperation between the medical profession and the private carriers would result in improved health care coverage, and that meetings such as this would help in increasing such cooperation."

Doctor Pierce is the KSMA senior delegate to the AMA. He is a member and past president of the Board of Directors of Kentucky Physicians Mutual.

Blood Banks Unit Names Dr. Chipps

H. Davis Chipps, M.D., Lexington, has been appointed Kentucky representative to the American Association of Blood Banks for 1961. Doctor Chipps is president of the Kentucky Society of Pathologists.

Professor of Surgery Appointed At U. K. College Of Medicine

Appointment of a chairman for the Department of Surgery at the University of Kentucky College of Medicine and a dean for the College of Dentistry has been announced by the university's board of trustees.

Ben Eiseman, M. D., professor of surgery at the University of Colorado School of Medicine since 1957, will serve as professor of surgery as well as chairman of the department at the U. of K. Medical Center.

The new dean is Alvin L. Morris, D.D.S., coming from the University of Pennsylvania School of Dentistry, where he was head of the Department of Oral Diagnosis. He will also serve as U. of K. professor of oral medicine.

Doctor Eiseman, a native of St. Louis, was graduated from Harvard Medical School in 1943. From 1950 to 1953, he was on the faculty at Washington University Medical School, holding the positions of assistant dean, instructor in surgery, assistant professor of surgery and director of the school's exchange program with Thailand. In 1953 he went to the University of Colorado School of Medicine as associate professor of surgery and was promoted to professor of surgery four years later. He served as acting dean in 1956-57. In 1953 he was appointed chief of Surgical Service, Veterans Administration Hospital, Denver.

Doctor Eiseman served in the Navy Medical Corps for three years during World War II and is now a commander in the Naval Reserve.

Doctor Morris was born in Detroit and spent his early childhood in London, Ky. He earned his Doctor of Dental Surgery degree from the University of Michigan in 1951 and a Ph.D. degree from the University of Rochester, N. Y., in 1957.

Another recent appointment to the U. of K. College of Medicine was that of Alberto Mazzoleni, M. D., Boston, Mass., as assistant professor of medicine. He also will serve as director of medical education at St. Joseph's Hospital, Lexington. After obtaining his degree in medicine at the University of Milan in 1952, Doctor Mazzoleni was a graduate student in cardiology at Harvard Medical School, served as Research Fellow in cardiology at Boston's Beth Israel Hospital, and was senior assistant resident in medicine at Boston City Hospital. Most recently he did research at Beth Israel Hospital on cardiac weights and their relation to electrocardiographic patterns.

U. L. School Of Medicine Gets Four New Instructors

Four appointments to the University of Louisville School of Medicine were announced recently by the university board of trustees. They were: David H. Dorton, M.D., instructor in ophthalmology in the department of surgery; Eugene T. Davidson, M.D., and Wilson C. Williams, Jr., M.D., instructors in medicine, and Marthe Saint Pierre, M.D., instructor in pediatric anesthesiology in the department of surgery.

Promotions went to Harold F. Berg, M.D., and J. Alex Haller, M.D., instructors who became assistant professors of surgery.

Resignations were accepted from Irvin L. Swartz, M.D., professor of pharmacology, who accepted a post at the University of Cincinnati, and Richard I-Hsiang Wang, M.D., instructor in medicine, who moved to Buffalo, N. Y.

Chief of VA Outpatient Clinic, Dr. Miller, Is Retiring

Oliver P. Miller, M. D., director of the Outpatient Clinic, Veterans Administration Regional Office, Louisville, is retiring this month after more than 40 years of federal service.



Dr. Miller

Doctor Miller is well known in medical and veterans' circles throughout Kentucky, having served in various capacities in both the Regional Office and the VA Hospital, Lexington. In 1943, he was named chief medical officer of the hospital and three years later became head of the Regional Office Medical Clinic. He has received numerous commendations from the VA for his service to Kentucky veterans.

Praise for the VA chief's cooperation in working with KSMA came from O. Leon Higdon, M.D., Paducah, chairman of the KSMA Committee on Federal Medical Services. Kentucky has been most fortunate in having Doctor Miller as administrative officer for the Hometown Medical Program, he said.

A veteran of both World Wars, Doctor Miller served as a first lieutenant in the Army Medical Corps in the first war and as a lieutenant colonel in the second. He was on duty with the VA as an Army officer at the Lexington hospital from June 1944 to March 1946. For this service he received the Army Commendation Ribbon—the only military officer of the Army Medical Corps assigned to the VA in this area to be so honored.

Doctor Miller, a native of Glens Fork, attended Lindsey Wilson Training School and was graduated from the University of Louisville School of Medicine in 1916. He practiced medicine in Columbia before joining the Veterans Administration in 1921. He is a member of the AMA, the KSMA, Jefferson County Medical Society, American Psychiatric Association, American Legion, Masonic Order, Kosair Temple and Rotary International.

He and Mrs. Miller will make their home in Columbia, where they have maintained an interest in community affairs and organizations.

Robert Pronko, M.D., Pineville, has been named Outstanding Man of the Year by the Pineville Rotary Club. He was chosen for "his devoted work to 'The Book of Job,' his outstanding achievements in the medical field, and his fine service to the community as a whole."

Dr. Knoefel Is Author of New Book, 'Radiopaque Diagnostic Agents'

Another name was added to the growing list of Louisville's physician-authors with the recent publication of "Radiopaque Diagnostic Agents" by Peter K. Knoefel, M.D., professor and chairman of the Department of Pharmacology at the University of Louisville School of Medicine.



Dr. Knoefel

Doctor Knoefel describes his book as a monograph on a particular kind of compound or substance used in medicine—directed particularly at radiologists. The first extensive summary in English on the subject, it is a collection of information not available in any other single place.

Much of the material originated in experiments the author carried out over the past several years in collaboration with the Radiology Department at the medical school. Twenty-four graphs by the school's Visual Education Department point up the text, and an extensive bibliography of 359 references is included. Charles C. Thomas, Springfield, Ill., is the publisher.

Doctor Knoefel has been a faculty member at the U. of L. medical school for 25 years. A native of New Albany, he received his M.D. degree from Harvard University in 1931.

New Kentucky Health Council Has Backing Of 100 Groups

The Kentucky Health Council was formed in Louisville on February 25—aimed at coordinating health and welfare activities throughout the state. Representatives of some 100 State agencies and health and civic groups launched the new organization by adopting bylaws and electing officers.

Howard Hunt, Louisville attorney and a past president of the Kentucky Tuberculosis Association, was named president.

First vice-president is Carl Cooper, M.D., Bedford, who has long been active in KSMA work. In 1959, Doctor Cooper received the Kentucky Public Health Association award as the person who had contributed most to the advancement of public health in Kentucky.

Other officers are: Charles Locke, Louisville businessman and a past state chairman of the Kentucky Junior Chamber of Commerce Health Committee, second vice-president; Miss Sara Stice, director of health education for the State Department of Health for 17 years, secretary, and Lyman Wagers, D.M.D., Lexington, past president of the Kentucky Dental Association, treasurer.

Also elected was an executive committee composed of Howard Bost, Ph.D., of the University of Kentucky Medical Center; Robert A. Thornbury of the Kentucky Heart Association; Martin F. Schmidt of the Kentucky Bottlers of Carbonated Beverages, and Thomas P. Summers, executive director of the Kentucky Tuberculosis Association.

Mrs. W. C. Cruise, Jr., Louisville, chairman of the steering committee which in 1958 laid the groundwork for the council, was named temporary executive secretary. Mrs. Cruse is a former president of the Kentucky Federation of Women's Clubs.

Mr. Hunt described the council as "a meeting ground for all groups working toward better health." It will concentrate on ways in which to improve the over-all health of the state, he said.

Governor Combs, a speaker at the meeting, promised he would do everything in his power to cooperate with the council and see that it gains State backing. He emphasized that increased appropriations for health by the next Legislature are imperative for the health programs operating in the state.

The importance of physician-leadership was stressed by a third speaker, A. R. Shands, Jr., M.D., of the du Pont Foundation, Wilmington, Del. Doctor Shands urged all members to go out and convince Kentucky doctors that they can do much to lift the health standards in the state by actively working with the council.

An independent agency, the council hopes to operate on its dues, which include: $25 annually for active membership, $10 for associate membership, $100 for a sustaining corporate member, and $25 for a sustaining individual member. It is also eligible for health grants.

First State TB Conference Set May 3-5 In Lexington

A blueprint for eradication of tuberculosis in the state is the goal of the first Kentucy Tuberculosis Conference called for May 3-5 in Lexington, according to Theodore A. Sanford, president of the Kentucky Tuberculosis Association.

Some 24 medical and health workers, sociologists, rehabilitation specialists and laymen have been invited to meet at Campbell House for the three days to study and recommend a solution to Kentucky's tuberculosis and health problems. Physicians on the list of conferees are: Kurt Deuschle, M.D., Marion Pearsall, M.D., and Alan Ross, M.D., of the University of Kentucky Medical Center; W. Duane Jones, M.D., Ashland; Richard E. Mardis, M.D., Maurice Kamp, M.D., Jack Chumley, M.D., Nathan Levene, M.D., Daniel Pickar, M.D., and E. R. Gernert, M.D., all of Louisville; Charles Martin, M.D., Lexington; Russell Hall, M.D., Prestonburg, and Edward West, M.D., of the State Department of Health, Frankfort.

The conference will be modeled after the Arden House Conference held at Harriman, N. Y., a little over a year ago when leading health authorities met to spell out ways to eliminate TB in the United States. Cosponsoring the program with the Kentucky Tuberculosis Association are the State Department of Health and the Tuberculosis Hospital Commission.

Hematology Course Rescheduled April 19-20 In Lexington

The postgraduate course on Hematology, originally set for March 8-9 at the University of Kentucky Medical Center in Lexington, has been rescheduled for April 19-20, the KSMA Postgraduate Medical Education Office announces. The course is acceptable for nine hours AAGP Category I Credit.

Five other offerings are given special emphasis in the office's regular listing of PG opportunities in Kentucky and adjacent states. Two of these have already been announced—a week's training in the field of Ob-Gyn available through 1961 at Louisville General Hospital and an eight-week intermittent course on Pediatrics held each Tuesday morning from April 4 through May 23 at Children's Hospital, Louisville.

The other three opportunities, yet in the tentative stage, are announced as follows: Program on Medicine in Harrodsburg, May 24-25; course on Chest Diseases in Louisville, June 14-15, and course on Ob-Gyn in Paducah, July 12-13.

Detailed information on the listings may be obtained from the Postgraduate Medical Education Office, 104 West Chestnut Street, Louisville 2. The telephone number is Juniper 7-7135.

The complete listing for the next three-month period follows:

April

Weekly through 1961	One week training in the field of OB-GYN, each week during 1961, except April 17-29, May 15-20, October 2-7, and October 23-28, limitation of two physicians per week; fee of $50 includes room at General Hospital, if desired. Enrollment should be made at least two weeks before desired participation. KAGP Category I Credit applied for.
4- through May 23:	Postgraduate course, "Pediatrics"; Children's Hospital, Louisville, Tuesday mornings, 9:30 to 12:30; fee, $30 for the course or $5 per day. Acceptable for KAGP Category 1 Credit of 24 hours.
14-15	Medical Legal Conference, sponsored by the AMA; Louisville.
17-18	Postgraduate course, "Pediatrics"; University of Nebraska College of Medicine, Omaha.
19	Fourteenth Trustee District meeting; Paintsville.
19-20	Postgraduate course, "Hematology"; postponed from March 8-9; University of Kentucky Medical Center, Lexington.
20	Thirteenth Trustee District meeting; Ashland.
20-23	Postgraduate course, "Otolaryngology"; University of Michigan Medical Center.
24-26	Postgraduate course, "Rheumatology"; University of Michigan Medical Center.
24-26	Postgraduate course, "Ophthalmology"; University of Michigan Medical Center.
26-28	Postgraduate course, "Ob-Gyn"; University of Tennessee Medical Center, Memphis.
27	Eleventh Trustee District meeting; Richmond.

NOTICE

The postgraduate course on Hematology which was originally scheduled for March 8-9, has been postponed until April 19-20, due to circumstances beyond our control. It will, as previously planned, be held at the University of Kentucky Medical Center in Lexington. The new programs will be issued shortly.

May

2	Postgraduate course, "Anesthesiology"; University of Nebraska, College of Medicine, Omaha.
3	Sixth Annual Trauma Day; University of Nebraska, Omaha.
4-5	Postgraduate course, "Urinary Tract Disease —Diagnosis and Treatment"; University of Tennessee, Memphis.
6-10	Medical Society of North Carolina, Annual Meeting; Asheville, N. C.
8-12	American College of Physicians, 42nd Annual Session; Miami Beach, Fla.
10-12	Kentucky Academy of General Practice, Annual Scientific Meeting; Kentucky Hotel, Louisville.
17-18	Postgraduate course, "Neurology"; University of Tennessee, Memphis.
17- June 7	Jefferson County Academy of General Practice, Spring Seminar; Wednesday nights.
18-20	Kentucky State Ob-Gyn meeting; Netherlands Hilton Hotel, Cincinnati.
24	Second and Third Trustee Districts, joint meeting.
24-26	Postgraduate course, "Diagnosis and Treatment—Emotional Disturbances in Children"; University of Tennessee, Memphis.
24-25	Postgraduate course, "Medicine" (Tentative); Harrodsburg, Ky.
25	First Trustee District meeting.

June

1	Twelfth and Fifteenth Trustee Districts, joint meeting; Cumberland Falls.
6	Kentucky Academy of General Practice Seminar; Harrodsburg; John M. Baird, M.D., Danville, chairman.
14-15	Postgraduate course, "Chest Diseases;" (Tentative), Louisville.

(Continued on Page 393)

KSMA Council, Committee Reports

Budget Committee

Keith P. Smith, M.D., Corbin, Chairman

Louisville **March 1, 1961**

The day-long meeting of the Budget Committee was held March 1 prior to the Executive Committee meeting of the Board on March 23 to review the financial transactions of the Association for the first six months of the 1960-61 fiscal year and discuss the proposed budget for the 1961-62 fiscal year for recommendations to the Executive Committee.

Statements of income and expense and financial condition of all the accounts of the Association were carefully reviewed. It was observed that the Association is operating well within its budget for this fiscal year, 1960-61.

The estimated assets as of June 30, 1961, and the proposed budget for 1961-62 were discussed. No notable increases or decreases are expected to occur in income during the coming year, with the possible exception of revenue from advertisers in The Journal due to the recession, the labeling regulations and other factors.

The McDowell House and Apothecary Shop receipts will be greater as restoration of the Apothecary Shop and Stamp Issue have brought the Home and Shop more widespread publicity. In line with decreased and increased income, The Journal and McDowell Fund expenses will change accordingly.

After full discussion of the individual items in the budget, it was unanimously voted by the Committee to recommend that the proposed budget be approved by the Executive Committee and sent to the Board of Trustees for adoption.

Rural Health Committee

Mitchell B. Denham, M.D., Maysville, Chairman

Brown Hotel, Louisville **March 2, 1961**

In its first meeting of the Associational year, the Rural Health Committee discussed its status as a committee of the Council on Communications and Public Service under the bylaw changes adopted by the 1960 House of Delegates.

The 1960 Rural Health Conference at Morehead was reviewed, and it was felt that this conference was enthusiastically received, inasmuch as 174 persons registered despite a heavy downpour of rain. The committee was very appreciative of the wonderful cooperation received from the faculty of the Morehead State College.

Also discussed were the suggested site and theme for the 1961 conference. It was the feeling of the committee that Owensboro would be the logical place, if it met with the approval of the Rural Health Council, and that the areas of tuberculosis and dentistry would be good topics for discussion.

Hospital Committee

J. B. Holloway, M.D., Lexington, Chairman

Kentucky Hotel, Louisville **February 2, 1961**

The Hospital Committee at its first meeting decided that it should get as much information as possible on hospitals in Kentucky, such as requisites for licensing, those accredited by the Joint Commission and also those that have applied for listing but have not been approved by the Joint Commission. It was felt this undertaking could be shared with the Kentucky Hospital Commission.

It was reported that there are 156 hospitals in Kentucky, 119 of which belong to the Kentucky Hospital Association and 67 are approved by the Joint Commission on Accreditation.

Another item discussed by the committee was the question of privileged communications. The committee recommended to the Council on Medical Education and Hospitals that the KSMA and the KHA point toward possible legislation in this matter.

Committee on Third Party Medicine

John S. Harter, M.D., Louisville, Chairman

Louisville **February 2, 1961**

The Committee on Third Party Medicine met in Louisville on February 2, 1961, with Doctor Harter presiding. As all five members are serving on this committee for the first time, much of the time was devoted to indoctrination.

The KSMA House of Delegates at its last meeting asked the Third Party Committee to: (1) study and attempt to formulate a statement on terms and conditions under which a physician may ethically accept salaried employment; and (2) consider the possibility of sponsoring a professional practice act.

The committee members studied material that was available on these two subjects and requested Headquarters Office to obtain additional information.

Technical Advisory Committee to the Indigent Medical Care Program

Clyde C. Sparks, M.D., Chairman

Lexington **February 16, 1961**

Considerable thought was given to the request of the Association's Board of Trustees that the Technical Advisory Committee recommend to the Governor's Advisory Council that the normal going fee of the physician in his local community be charged for services rendered under the Indigent Medical Care Program and that physicians be paid on a proportionate basis out of the funds set aside for physicians under the program after the end of each month. The Committee thought "under the present limitations" should be inserted after the words proportionate basis.



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This therapeutic proficiency results not merely from the high level of pharmacodynamic activity of Pro-Banthīne but also from a favorable balance of its actions on both autonomic ganglia and parasympathetic effector organs. The total effect of this activity permits doubling or tripling the usual dosage to relieve severe or intractable conditions without unduly extending or aggravating secondary actions.

Less than a satisfactory response[1] to Pro-Banthīne may often be simply a result of less than adequate dosage.

Pro-Banthīne, brand of propantheline bromide, is supplied in tablets of 15 mg. for oral administration in conditions such as peptic ulcer, gastritis, duodenitis, pylorospasm, biliary dyskinesia and spastic colon, and in ampuls of 30 mg. for intramuscular or intravenous administration in conditions such as ureteral spasm and pancreatitis in which prompt and vigorous effects are required or when nausea and vomiting preclude oral administration.

Usual adult dosage: One tablet four times daily. Up to four tablets may be administered four times daily for severe manifestations.

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Brand of propantheline bromide with thiopropazate dihydrochloride

(Not more than four tablets daily.)

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1. Krantz, J. C., Jr., and Carr, C. J.: The Pharmacologic Principles of Medical Practice, Baltimore, The Williams & Wilkins Company, 1958, p. 843.

G. D. SEARLE & CO., CHICAGO 80, ILLINOIS. *Research in the Service of Medicine*

Application

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1961 Annual Meeting — Kentucky State Medical Association

Columbia Auditorium — **Louisville, Kentucky** — **September 19, 20 and 21**

Fill Out and Mail to:

J. THOMAS GIANNINI, M.D., Chairman

Committee on Scientific Exhibits

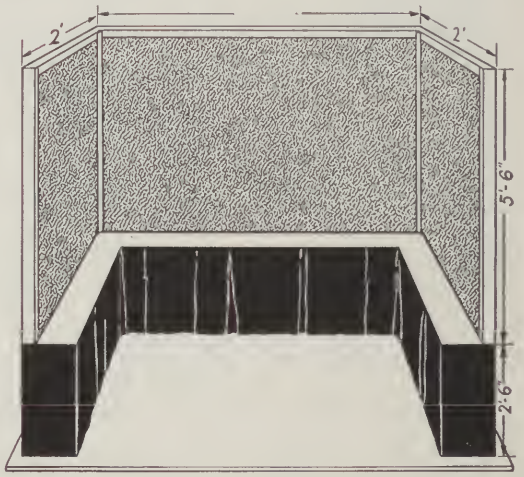
129 Medical Arts Building

1169 Eastern Parkway

Louisville 17, Kentucky

Applications for space should be received before July 1, 1961

Dimensions and structure of K.S.M.A. Scientific booth are shown in accompanying illustration



1. Title of Exhibit: .....

2. Description or nature of exhibit: (Attach brief description to this blank).

3. Will you require shelf space? .....

4. Give approximate amount of wall space needed. (Included in total space is two side walls of two feet in length) .....

5. Name of institution co-operating in the exhibit (if desired) .....

6. Name of exhibitor: .....

..... (Street & No.) ..... (City)

The Kentucky State Medical Association will provide without cost to the exhibitor the following: Exhibit space, shelves, sign for booth, current, bracket lights, provided all items are approved in advance by the committee.

Cost of transporting exhibits to the meeting must be borne by the individual exhibitor as well as costs of cards, signs, etc., which are a part of the exhibit.

View boxes, furniture, decorations, etc., may be rented, if desired, by applying directly to Jos. T. Griffin Company, 704 West Main Street, Louisville 2, who supply equipment for the annual K.S.M.A. meeting.

POSTGRADUATE OPPORTUNITIES

(Continued from Page 389)

22	Kentucky Academy of General Practice Seminar; Henderson; Robert Sumner, M.D., Henderson, chairman.
22	Joint meeting of the Fourth & Sixth Trustee Districts, Glasgow.
26-30	AMA Annual Meeting, New York City.

July

6	KAGP Seminar; Paintsville; George P. Archer, M.D., and James W. Archer, M.D., co-chairmen.
12-13	Postgraduate course, "Ob-Gyn"; (Tentative); Paducah.

Blue Cross Elects Officers

The board of trustees of the Blue Cross Hospital Plan, Inc., Louisville, announces the election of the following officers for 1961: A. E. Norman, chairman; James F. Bleakley, vice-chairman; Charles W. Allen, Jr., secretary, and J. B. Hendrick, Jr., treasurer.

Blue Cross had 150,476 cases and paid $15,802,-323.97 to hospitals for care of members in 1960, as compared to $12,911,367.50 in the previous year, it was reported by William P. Kelly, outgoing board chairman.

Nurse Group Elects U. K. Dean

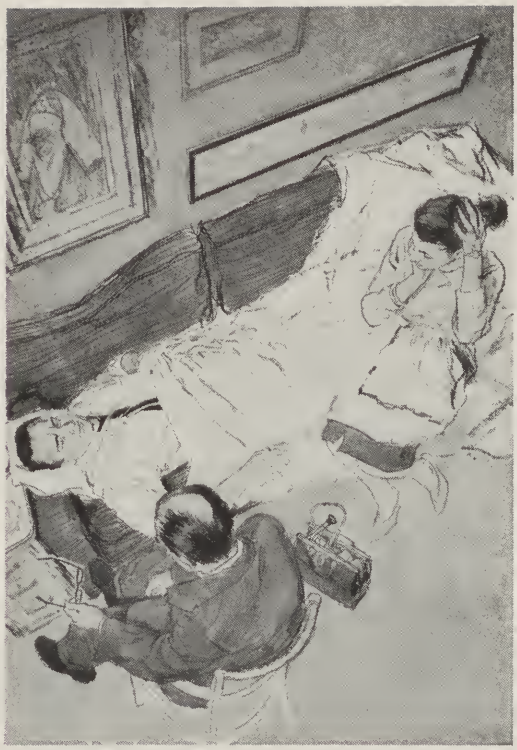
Miss Marcia Dake, Ed.D., dean of the College of Nursing at the University of Kentucky Medical Center, was chosen president-elect of the Kentucky League for Nursing at the group's annual meeting in Louisville on March 10. Miss Martha Jane Jordan, Louisville, was installed as president to succeed Mrs. Nancy Blakeman, Lexington, who became a board member. Other officers elected were: Miss Elise E. Meyer, Louisville, vice-president; Miss Elsie Pearson, Louisville, treasurer, and Miss Beulah Miller, Ed. D., Berea, board member. Mrs. Marjorie Tyler, Louisville, was renamed executive secretary.

KSMA Adds Six New Members

Six physicians have become members of KSMA since The Journal's last report. They are:

Clegg Austin, M. D., Murray
Carl T. Clark, M. D., Lexington
Frank B. Crawford, M. D., Paducah
William Massey, M. D., Burnside
Curtis Lee Songster, M. D., Vine Grove
L. N. Turk, M. D., Lexington

Ralph E. Whitehead, M.D., has started practice in Louisville. A native of Louisville, Doctor Whitehead was graduated from the University of Louisville School of Medicine in 1959 and interned at Kentucky Baptist Hospital. He served two years in the U.S. Marine Corps.



DORNWAL® HAS BEEN CALLED "THE GENERAL TRANQUILIZER FOR GENERAL PRACTICE."

Suppose the physician visiting this patient finds that he has to be hospitalized. Certainly he wants an alert but not excited fellow who can respond to the history and physical on admission. Depending on the condition, of course, the thing to do is to give the patient one or two tablets of Dornwal before he ever leaves his home.

Dornwal will calm the patient but won't make him drowsy or give him feelings of depersonalization. And what's more, while Dornwal most assuredly tranquilizes, it won't interfere with most other medications that your subsequent examination or laboratory studies may indicate.

Since every man in general practice encounters such situations almost daily, it makes good sense to keep some tablets in one's bag, doesn't it? We will be glad to send you a supply.

Dosage: One or two 200 mg. tablets three times a day. Children, age 6 to 16, one or two 100 mg. tablets two times a day. Administration limited to three months' duration.

Supplied: 200 mg. yellow scored tablets, and 100 mg. pink tablets, each in bottles of 100 and 500.

P.S. For the "Genericist", Dornwal is amphenidone

No absolute contraindications to the use of Dornwal are known. There have been no reports or evidence of habituation, addiction or drug tolerance in animal or clinical studies. Dornwal is relatively free from untoward effects when administered at recommended dosages.

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County Society Reports

Graves County

James Steele Robbins, M.D., is the newly-elected president of the Graves County Medical Society, succeeding Thomas Stone, M.D. Other 1961 officers are Jacob M. Mayer, M.D., vice-president, and W. B. Simpson, M.D., secretary-treasurer. William H. Fuller, M.D., was named delegate and Allison Reeves Morgan, M.D., alternate delegate to the KSMA Annual Meeting in September. All are Mayfield physicians.

Harlan County

Doane Fischer, M. D., is the newly-elected president of the Harlan County Medical Society. Other 1961 officers are T. Garnett Craft, M. D., vice-president, and William H. Potter, M. D., secretary-treasurer. E. M. Howard, M. D., and David M. Greeley, M. D., were elected delegates to the 1961 Annual Meeting of KSMA.

Henderson County

The Henderson County Medical Society has announced the election of the following officers: William Herschell Cave, M.D., president; Donald A. Cantley, M.D., vice-president, and Julian B. Cole, M.D., secretary-treasurer. Kenneth M. Eblen, M.D., was named delegate to the 1961 Annual Meeting of KSMA.

Marshall County

The Marshall County Medical Society has elected J. R. Miller, M. D., Benton, as president. He succeeds William J. Colburn, M. D., Calvert City, who was named the society's delegate to the 1961 Annual Meeting of KSMA. Also elected were: George C. McClain, M. D., Benton, vice-president, and Harold L. King, M. D., Benton, secretary-treasurer.

McCracken County

A five-point recommendation on the indigent medical care program was adopted by the McCracken County Medical Society at its January meeting, after a reading and discussion of the KSMA communication on the subject. Delegates were instructed to present the society's action at the state level.

It was suggested:

1. That allocation of funds for indigent care be made on the basis of the indigent per capita in the state.

2. That the present fee schedule and funds available for the program are totally inadequate to give proper medical care to those covered by the new legislation and that additional funds will have to be obtained from the General Assembly of Kentucky and the Federal Government to assure that the program works and that adequate care can be given.

3. That in areas of the state where local medical care for the indigent is adequate, the new program should not supplant the existing one.

4. That the medical profession throughout the state has taken care of the sick on a charity basis, and yet this fact has never been adequately publicized.

5. That the State Commission eliminate the bureaucracy of administration and cut down the program's cost as much as possible.

The scientific session was presented by D. A. Ross, M.D., head of the Department of Medical Physics, Oak Ridge Institute of Nuclear Studies, Oak Ridge, Tenn.

Muhlenberg County

The Muhlenberg County Medical Society devoted its March meeting to a study of the Kentucky Medical Care Program, with Mrs. Mary M. Morse, Madisonville, social service supervisor of the Division of Public Assistance, as the principal speaker. Mrs. Mary McReynolds and Mrs. Mae Driskell of the Greenville Office of Public Assistance assisted in explaining the program.

Mrs. Morse outlined the four categories of Public Assistance: Old Age Assistance (OAA); Aid to Dependent Children (ADC); Aid to the Needy Blind (ANB), and Aid to the Permanently and Totally Disabled (APTD).

The society in executive session considered a statement from the Warren County Medical Society pertaining to the Kentucky Medical Care Program. The secretary was directed to send a summary of the discussion to the Warren County Group.

State M.D.'s On ACCP Program

Oren A. Beatty, M.D., Louisville, and Lloyd D. Mayer, M.D., Lexington, are scheduled to participate in the program of the American College of Chest Physicians at its 27th annual meeting at the Commodore Hotel in New York City, June 22-26.

A joint session with the Section on Diseases of the Chest of the American Medical Association will be held at the Coliseum on June 26. This will be the first joint meeting in the history of the two societies.

Dr. Combs Is 'Man Of the Year'

Cooley L. Combs, M.D., Hazard, was honored recently as Man of the Year on the Hazard Civic Night program presented by the Chamber of Commerce, Junior Chamber of Commerce and five civic groups. Lt. Gov. Wilson W. Wyatt was the principal speaker.

An active civic worker, Doctor Combs is a member of the Hazard School Board and president of the Kentucky School Boards Association. He is chairman of the KSMA Committee to Study the Constitution and Bylaws.

Paul R. Kleykamp, M.D., has started practice in Ashland in association with **C. W. Franz, M.D.**, and **Eugene Slusher, M.D.**, Born in Ashland, Doctor Kleykamp earned his M.D. degree from the Medical College of Virginia in 1952 and interned at St. Mary's Hospital, Huntington, W. Va. He served three years in the U.S. Navy with the U.S. Fleet Sonar School.

NEWS ITEMS

William W. Adams, M.D., a native of Stanford, has opened an office in Lexington. He previously practiced at Norfolk, Va. Doctor Adams was graduated from Meharry Medical College in 1951 and served his internship and residency in obstetrics and gynecology at Lincoln Hospital, Durham, N. C. He was in the U.S. Infantry six months.

Clegg Farmer Austin, M.D., has joined the staff of the Houston-McDevitt Clinic in Murray. His specialty is pediatrics. Born in Murray, Doctor Austin was graduated from the University of Louisville School of Medicine in 1957. He interned at Louisville General Hospital and took residency training at Louisville Children's and General Hospitals.

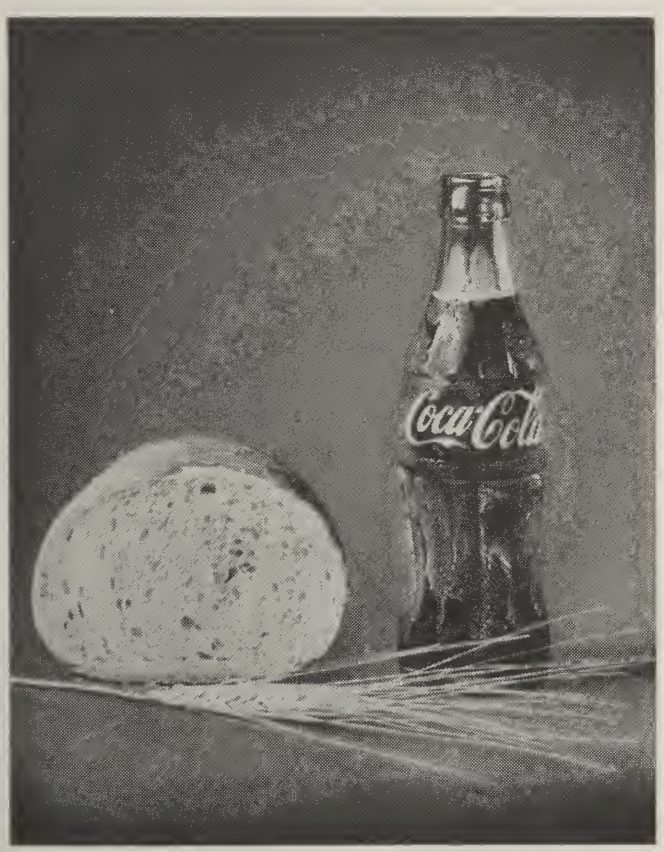
Paul A. Bryan, M.D., Ashland physician, has established a branch office in Flatwoods.

James G. Wilhite, M.D., a native of Paintsville, has started practice in Lexington. His specialty is pediatrics. Doctor Wilhite received his M.D. degree from the University of Tennessee in 1957 and interned and took residency training at three Memphis hospitals—the City of Memphis, John Gaston and Le Bonheur Children's.

Russell E. Teague, M.D., State Commissioner of Health, is a member of the new Kentucky Advisory Committee on Nuclear Energy appointed by Governor Combs. The committee, headed by **Attorney General John B. Breckinridge,** will advise the Governor on steps that should be taken in developing nuclear energy for the benefit of the economy and the citizens of the state. Last year Kentucky was the first state to file with the Atomic Energy Commission for authority to regulate possession and use of nuclear-energy material.

Walden R. Smith, M.D., Louisville, has been assigned to the preventive medicine section of Ireland Army Hospital at Fort Knox as physician in the Federal Service Civilian Employees Dispensary. A 1946 graduate of the University of Louisville School of Medicine, Doctor Smith was a member of the Army Medical Corps from 1947 to 1953.

Wilk O. West, M.D., a native of Princeton, W. Va., has joined the staff of the Lexington Clinic, Lexington. He specializes in internal medicine and hematology. Doctor West was graduated from the Medical College of Virginia in 1955, interned at Memorial Hospital, Charleston, W. Va., and took residency training in hematology at Ohio State University Hospital.



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In Memoriam

FORREST M. GRIFFIN, M.D.
Hawesville
1878-1961

Forrest M. Griffin, M.D., who retired in 1956 after practicing in Hawesville and Hancock County for 57 years, died February 3 at the home of his son in Owensboro. He was 83.

A native of Hancock County, Doctor Griffin was graduated from the University of Louisville School of Medicine in 1898 and started practice at the age of 21.

L. H. MEDLEY, M.D.
Owensboro
1903 - 1961

Lawrence Hubert Medley, M.D., Owensboro pediatrician, died suddenly of a heart attack March 8 at his home in Owensboro. He was 58.

Doctor Medley was graduated in 1930 from the University of Louisville School of Medicine. A former director of the Daviess County Health Department, he had specialized in pediatrics since 1946.

S. A. BLACKBURN, M.D.
Versailles
1875 - 1961

Smith Alford Blackburn, M. D., retired physician of Versailles, died March 2 at the Woodford Memorial Hospital after a long illness. He was 85.

A native of Spring Station, Doctor Blackburn was graduated from George Washington Medical School, Washington, D. C., in 1900. He began his career as contract surgeon for a construction company and practiced in Versailles until his retirement in 1952. During World War I, he was assistant camp surgeon at Camp Gordon, Ga.

JAMES W. SCUDDER, M.D.
Richmond
1874-1961

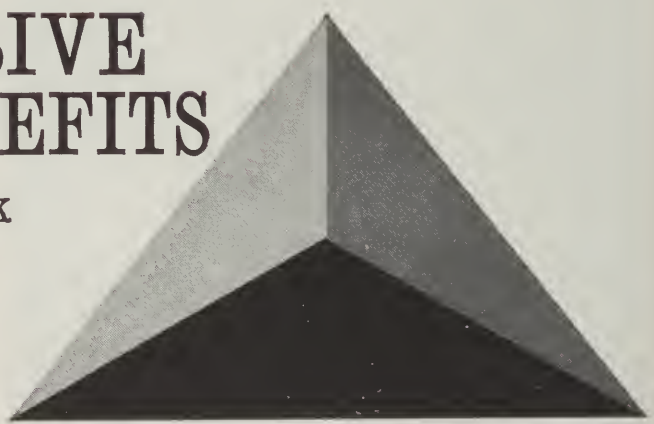
James W. Scudder, M.D., retired Richmond physician, died February 4 at a Lexington hospital after a long illness. He was 87.

An 1898 graduate of the University of Louisville School of Medicine, Doctor Scudder began practice in Madison County and was first physician for Eastern State College. He retired from practice in 1954.

Members of the **McCracken County Medical Society** met jointly with the McCracken County Bar Association in Paducah recently to consider mutual problems of the medical and legal professions. Four films of interest to both professions were shown.

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A non-profit psychiatric institution, offering modern diagnostic and treatment procedures—insulin, electroshock, psychotherapy, occupational and recreational therapy—for nervous and mental disorders. The Hospital is located in a 75-acre tract, amid the scenic beauties of the Smoky Mountain Range of Western North Carolina, affording exceptional opportunity for physical and emotional rehabilitation. The OUT-PATIENT CLINIC offers diagnostic services and therapeutic treatment for selected cases desiring non-resident care.

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IN THE BOOKS



MEDICAL CARE OF THE ADOLESCENT: by J. Roswell Gallagher, M.D., published by Appleton-Century-Crofts, Inc., New York City; 369 pages; price, $10.

This is the most complete book on the medical care of the adolescent child that has been available to the physician. Besides discussing in detail the various diseases that require attention in the adolescent age group, it outlines in fairly specific detail the emotional needs of the adolescent. The book develops for the physician a method of approach, and outlines history taking and examination for this particular age group.

The book is fairly easily read, and may also be used as a ready reference on specific problems. There are various charts for recording data, particularly about physical fitness, that the physician will find quite helpful. The general theme that adolescence is a particular and specific medical problem becomes somewhat tiring, but the section on emotional and special physical problems adds to our general understanding.

In conclusion, all physicians caring for adolescents will find this a very helpful reference book and an enjoyable one to read at one's leisure.

Joseph A. Little, M.D.

OCCUPATIONAL DISEASES AND INDUSTRIAL MEDICINE: by Rutherford T. Johnstone, M.D., and Seward E. Miller, M.D.; published by W. B Saunders Company, Philadelphia and London; 482 pages; price, $12.

To the private practitioner who has accepted the responsibility to provide medical services to an industry, this book might well prove a boon. In it he will find the essentials of industrial medicine clearly defined. The authors recognize that exhaustive consideration of specific problems is impossible in a single volume if the book is to serve its stated primary function as a sort of handbook for neophytes in the practice of industrial medicine and a textbook for medical students.

In addition to excellent chapters devoted to problems encountered in industry, the authors clearly define the objectives and scope of occupational medicine and offer sound, constructive advice regarding organization and the proper roles of all those concerned with worker health. Some will be concerned with the lack of specific directions regarding the treatment of many of the conditions discussed.

It is probable, in view of the fact that both authors have rich clinical experience in the field, that their specific intention is to educate one to the *recognition* of the problem area. In allotting scant room to treatment, they reiterate that the keystone of occupational medicine is prevention and further that *recognition* of the problem is the sine qua non for prevention or rational treatment. A bibliography follows each chapter, and the interested physician may expand his understanding of the various aspects of specific problems from the references given.

I feel that the authors ought to have included information on the eyes in industrial practice and that they also might have given more space to the many aspects of worker limitation due to disability as well as making the accepted physical classification standards known.

In a single volume treatment of a broad subject the authors have scoped the field in a capable fashion. This book will undoubtedly find favor with the enlarging number of private practitioners who provide part-time care for the worker on the job.

Leslie Van Nostrand, M.D.

Medical, Surgical and Gynecological COMPLICATIONS OF PREGNANCY: by The Staff of the Mount Sinai Hospital, New York City; edited by Alan F. Guttmacher, M.D. and Joseph J. Rovinsky, M.D., published by The Williams and Wilkins Company, Baltimore, Md.; 625 pages; price $16.50.

This book was written for the purpose of assisting the obstetrician or general practitioner with problems that may arise in the care of an obstetrical patient. It was certainly not conceived with the idea of replacing or improving a standard textbook of obstetrics.

The department of obstetrics at the Mount Sinai Hospital has the unique arrangement whereby it has interwoven the medical and surgical departments into its own for the betterment of the obstetrical patient. There have been created 10 specialty clinics within the framework of the department. Each clinic is under the direction of a man well versed in his field and willing to work in conjunction with the representative of the obstetrical department.

As mentioned in the preface of the book, the authors have endeavored to keep the material current and have excluded references published before 1950.

One of the things that makes this volume desirable for a personal library is the attention given to therapeutic measures. Throughout the various sections devoted to both the frequent and infrequent complications, specific drug therapy and dosage is discussed. One of the 14 sections of the book is devoted to infections, and includes a chapter which discusses

(Continued on Page 402)



When the evidence indicates smooth muscle spasm,

good judgment can render it "null and void"
by a ruling in favor of
dependable autonomic sedation

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	In each Tablet, Capsule or tsp. (5 cc.) of Elixir	In each Extentab
Hyoscyamine sulfate	0.1037 mg.	0.3111 mg.
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Hyoscine hydrobromide	0.0065 mg.	0.0195 mg.
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Relaxation — obtained *within minutes* with ROBAXIN Injectable.
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Nine published studies show:

Beneficial results in 90% of cases of skeletal muscle spasm with ROBAXIN.

Clinical responses to ROBAXIN therapy, as reported by investigators:

"*marked*" in 26 out of 33 patients, moderate in 6...[1] "*pronounced*" in 37 out of 58 patients, moderate in 20...[2] "*good*" in 25 out of 38 patients, moderate in 6...[5] "*excellent*" in 14 out of 17 patients, moderate in 2...[6] "*significant*" in 27 out of 30 patients...[7] "*gratifying*" in 55 out of 60 patients...[8] "*effective*" in 32 out of 32 patients...[9] "*marked*" in 27 out of 46 patients, moderate in 6...[4] "*good*" in 57 out of 60 patients, moderate in 3.[10]

ROBAXIN exhibits "great freedom from undesired side reactions,"[3] does not produce "concomitant euphoria or partial anesthesia,"[10] and permits patients to retain concentration and awareness.[8]

For immediate relaxation of acute skeletal muscle spasm:

Robaxin® Injectable — each ampul containing 1.0 Gm. of methocarbamol in 10 cc. of sterile solution.

For initiating therapy or maintaining relaxation induced by ROBAXIN Injectable:

Robaxin® Tablets — 0.5 Gm. (white, scored) in bottles of 50 and 500.

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Robaxisal® Tablets — Robaxin with Aspirin

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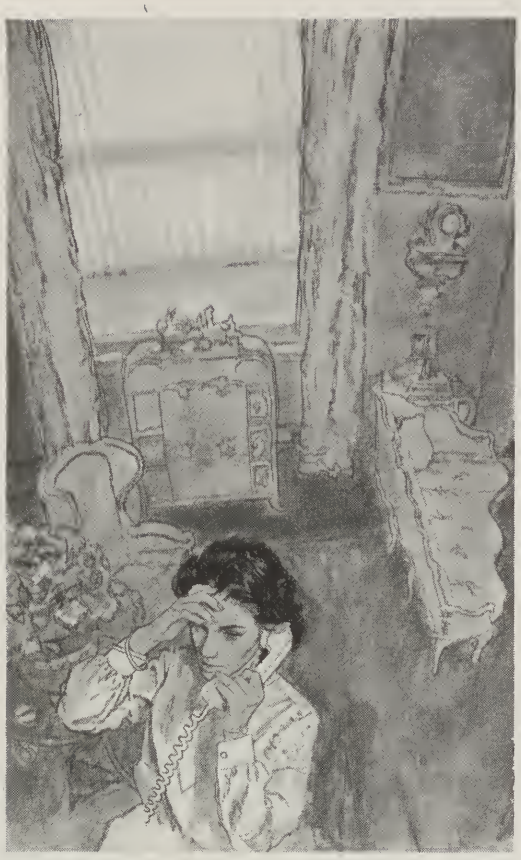
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Literature available to physicians on request.

REFERENCES: 1. Carpenter, E. B.: Southern M.J. 51:627, 1958. 2. Forsyth, H. F., J.A.M.A. 167:163, 1958. 3. Hudgins, A. P.: Clin. Med. 6:2321, 1959. 4. Grisolia, A., and Thomson, J. E. M.: Clin. Orthopaedics 13:299, 1959. 5. Lewis, W. B.: California Med. 90:26, 1959. 6. O'Doherty, D. S., and Shields, C. D.: J.A.M.A. 167:160, 1958. 7. Park, H. W.: J.A.M.A. 167:168, 1958. 8. Plumb, C. S.: Journal-Lancet 78:531, 1958. 9. Poppen, J. L., and Flanagan, M. E.: J.A.M.A. 171:298, 1959. 10. Schaubel, H. J.: Orthopedics 1:274, 1959.

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Take, for instance, the woman in our picture, suffering from a really severe tension headache. Aspirin she has tried, of course; but suppose she's called you and you prescribed Dornwal. What would you expect?

First, let us say you told the druggist to indicate the dosage that our clinical research has shown is useful in these cases — 1 or 2 tablets t.i.d. In all probability, she would experience relief of pain and a general relaxation in less than an hour. If she is doing her housework, she could go on with it, because she wouldn't get sleepy.

Dornwal is one tranquilizer that doesn't make people sleepy. It's a tranquilizer pure and simple. Its effectiveness you will see clearly the next time you encounter a patient given to tension headaches. Try Dornwal and see the results.

Dosage: One or two 200 mg. tablets three times a day. Children, age 6 to 16, one or two 100 mg. tablets two times a day. Administration limited to three months' duration.

Supplied: 200 mg. yellow scored tablets, and 100 mg. pink tablets, each in bottles of 100 and 500.

P.S. For the "Genericist", Dornwal is amphenidone

No absolute contraindications to the use of Dornwal are known. There have been no reports or evidence of habituation, addiction or drug tolerance in animal or clinical studies. Dornwal is relatively free from untoward effects when administered at recommended dosages.

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IN THE BOOKS

(Continued from Page 398)

antibiotics and chemotherapy. Many little assists to the obstetrician are included, such as the management of newborn infants of diabetic mothers, hazards of radiation, and mental and emotional problems. Other serious complications are described with explanations of their course and therapeutic agents available. The possible application of abortion and sterilization is considered.

I believe that a man training to do obstetrics should read this book in its entirety, and a man long established in this field would probably find it his most useful reference book. Complications that I consider myself well qualified to handle have been beautifully outlined, and others in which I have had little experience are set forth with some worthwhile suggestions. I intend to have a copy for my own personal use.

Rudy F. Vogt, M.D.

Planning A Trip Abroad? Uncle Sam Has Health Hints For You

Health hints for world travelers are given in a series of leaflets prepared for distribution by the U S. Department of Health, Education and Welfare, Public Health Service, Washington, D. C. Immunization requirements for specific areas are included.

One folder contains information for travel in Mexico, Central and South America, and the Caribbean. Another covers Asia, including Japan, Indonesia and the Philippines, and Australia and New Zealand. A third tells precautions that should be taken for a safe trip to Africa, including Malagasy Republic and neighboring islands. "Health Hints for Travel In Europe" is the title of a fourth leaflet. There's also a companion leaflet entitled "So You're Going Abroad . . . Health Hints for Travelers."

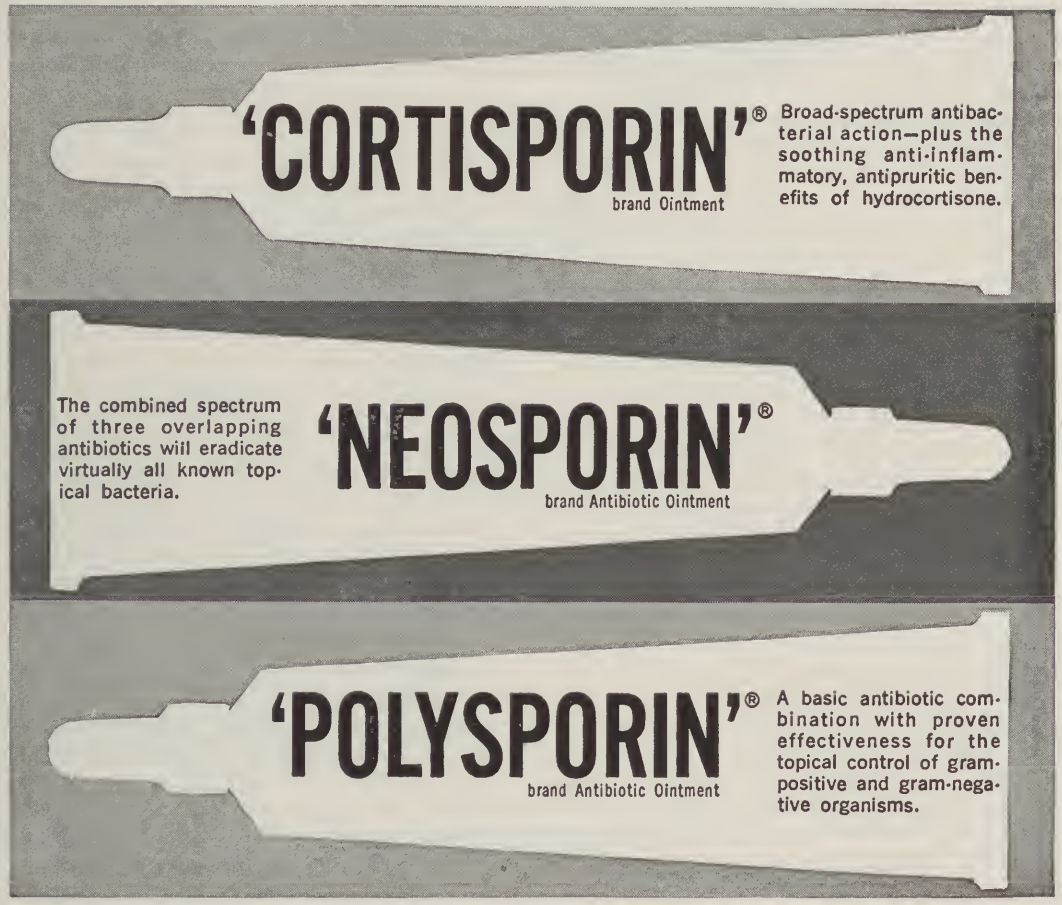
Copies of the folders may be obtained at 5 cents each from the Superintendent of Documents, Government Printing Office, Washington 25, D. C.

PERTINENT PARAGRAPHS

The American Goiter Association, Inc., has announced a three-day meeting at the Warwick Hotel in Philadelphia, May 4-6. Thirty-five scientific presentations are scheduled on the preliminary program released by the association.

The American College of Obstetricians and Gynecologists will initiate a program of postgraduate courses at its 10th Anniversary Clinical Meeting April 20-28 at the Americana Hotel, Bal Harbour, Fla. The courses, to be held April 21-28, will cover five subjects: genetics, statistics, radiation physics, parenteral nutrition and steroid metabolism. More than 2,000 specialists and their guests are expected to attend the general clinical session April 24-28, according to an ACOG news release.

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Contents per Gm.	'Polysporin'®	'Neosporin'®	'Cortisporin'®
'Aerosporin'® brand Polymyxin B Sulfate	10,000 Units	5,000 Units	5,000 Units
Zinc Bacitracin	500 Units	400 Units	400 Units
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Hydrocortisone	—	—	10 mg.
Supplied:	Tubes of 1 oz., ½ oz. and ⅛ oz. (with ophthalmic tip)	Tubes of 1 oz., ½ oz. and ⅛ oz. (with ophthalmic tip)	Tubes of ½ oz. and ⅛ oz. (with ophthalmic tip)

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From the files of the COMMITTEE FOR THE STUDY OF MATERNAL MORTALITY



CASE #77—This patient was a 41 year old married white para 5 whose expected date of delivery was September 2, 1959. The patient had tuberculosis in 1948, and had been treated by induction of pneumothorax and three pneumonolyses. Her disease was ultimately arrested.

Despite her debilitating disease, the patient gave no history of obstetric complications in previous pregnancies. Her five children ranged in ages from 10 to 3 years, and all were healthy. The patient had had three spontaneous abortions at approximately twelve weeks' gestation, one in 1956 and two in 1957. A curettage was necessary each time to control the bleeding and she had been transfused twice.

The present pregnancy had been uneventful, except for the patient's complaint that she had not been feeling well. The hospital chart provided no further information regarding the prenatal course.

The patient's membranes ruptured spontaneously on August 27, 1959, and she was admitted to the hospital. The cervix was long and uneffaced, with the presenting head floating above the inlet. She was sent home and returned to the physician's office three days later, when there was no further drainage of amniotic fluid. A prophylactic oral antibiotic was prescribed.

The patient was rehospitalized at 8 p.m. on September 1, 1959, with uterine contractions recurring every few minutes. The cervix was long and uneffaced. She was given 75 mg of Phenergan at 8:10 p.m., and 50 mg of Demerol at 8:20 p.m. A second 50 mg injection of Demerol was given at midnight.

At 4:30 a.m. on September 2, the patient was thought to be in active labor. Contractions recurred at five-minute intervals and were strong, although the cervix on rectal examination was described as still thick and only one finger dilated. She was given 50 mg Demerol at 5:30 a.m. when the contractions were every three minutes, although no further cervical dilation had taken place. At 6:15 a.m., a thick rim of cervix remained and the contractions were noted at two- to three-minute intervals.

At 6:25 a.m., the patient was taken to the delivery room and saddle block anesthesia was induced with heavy Nupercaine. The blood pressure immediately after saddle block was 106/64. After approximately 15 minutes it was noticed that the patient's legs were cyanotic. The blood pressure was 60/40, and the pulse was thready, though slow.

An attempt was made to start an intravenous infusion at this time, and oxygen was administered by mask. Because of the peripheral vascular collapse, it was necessary to cannulate a vein. She was given 1,000 cc of 5% glucose in water with Levophed, but no change was noted in the blood pressure. It was apparent that the patient was moribund. The fetal head during this time was on the perineum, but since the fetal heartbeat could not be heard, no attempt at delivery was made, all efforts being directed to combating the acute vascular collapse.

Just before the patient died, the infant, a stillborn girl, was delivered from LOA after midline episiotomy by low forceps. It was apparent that the infant had been dead for only a short time. Permission for an autopsy was obtained. The cause of death was thought to be exsanguination from spontaneous rupture of the uterus. There was a large right-sided uterine rupture without broad ligament hematoma. The rupture must have occurred almost simultaneously with the administration of the anesthetic, since the patient had not complained of sudden pain.

Comments

The Committee classified this case as a direct, nonpreventable obstetric death. Rupture of the gravid uterus is still one of the most serious catastrophes in obstetrics and in spite of modern therapy the maternal mortality associated with this accident remains high. The causes of traumatic rupture of the uterus include internal version and breech extraction, difficult forceps operations, and injudicious use of pitocin.

Spontaneous ruptures are usually associated with great multiparity, cephalopelvic disproportion, malpresentation and hydrocephalus. Unnecessarily traumatizing fundal pressure to aid the delivery of the infant or to relieve shoulder dystocia may also rupture the uterus. Scars at the site of cornual resection are also vulnerable spots in this connection.

Awareness of the possibility of uterine rupture in a given case is the first step toward prevention of the accident. The clinical picture depends on the type and timing of rupture. During labor, the signs of uterine irritability may resemble those observed in abruptio placentae. Postpartum uterine rupture may escape early detection because of the paucity of signs and symptoms; eventually, progressively deepening signs of hemorrhagic shock together with development of peritoneal irritation, flank dullness and fluid wave, make the diagnosis clear. Immediate laparotomy with blood replacement is necessary for the salvage of these patients.



Vertigo is reversible

Antivert® STOPS VERTIGO

moderate to complete relief of symptoms in 9 out of 10 patients'



Prescribe one ANTIVERT tablet (or 1-2 teaspoonfuls ANTIVERT syrup) 3 times daily, before each meal, for prompt relief of vertigo, Meniere's syndrome and allied disorders. Side effects are short-lived, usually only harmless flushing and tingling associated with vasodilation. ANTIVERT is contraindicated in severe hypotension and hemorrhage.

Supplied: Small blue-and-white scored tablets (meclizine HCl 12.5 mg. and nicotinic acid 50 mg.) in bottles of 100. Syrup in pint bottles. Prescription only. Bibliography available on request.

And for your aging patients—
NEOBON® Capsules: five-factor geriatric supplement.

Reference: 1. Scal, J. C.: Eye Ear Nose & Throat Month. 38:738 (Sept.) 1959.

ROERIG

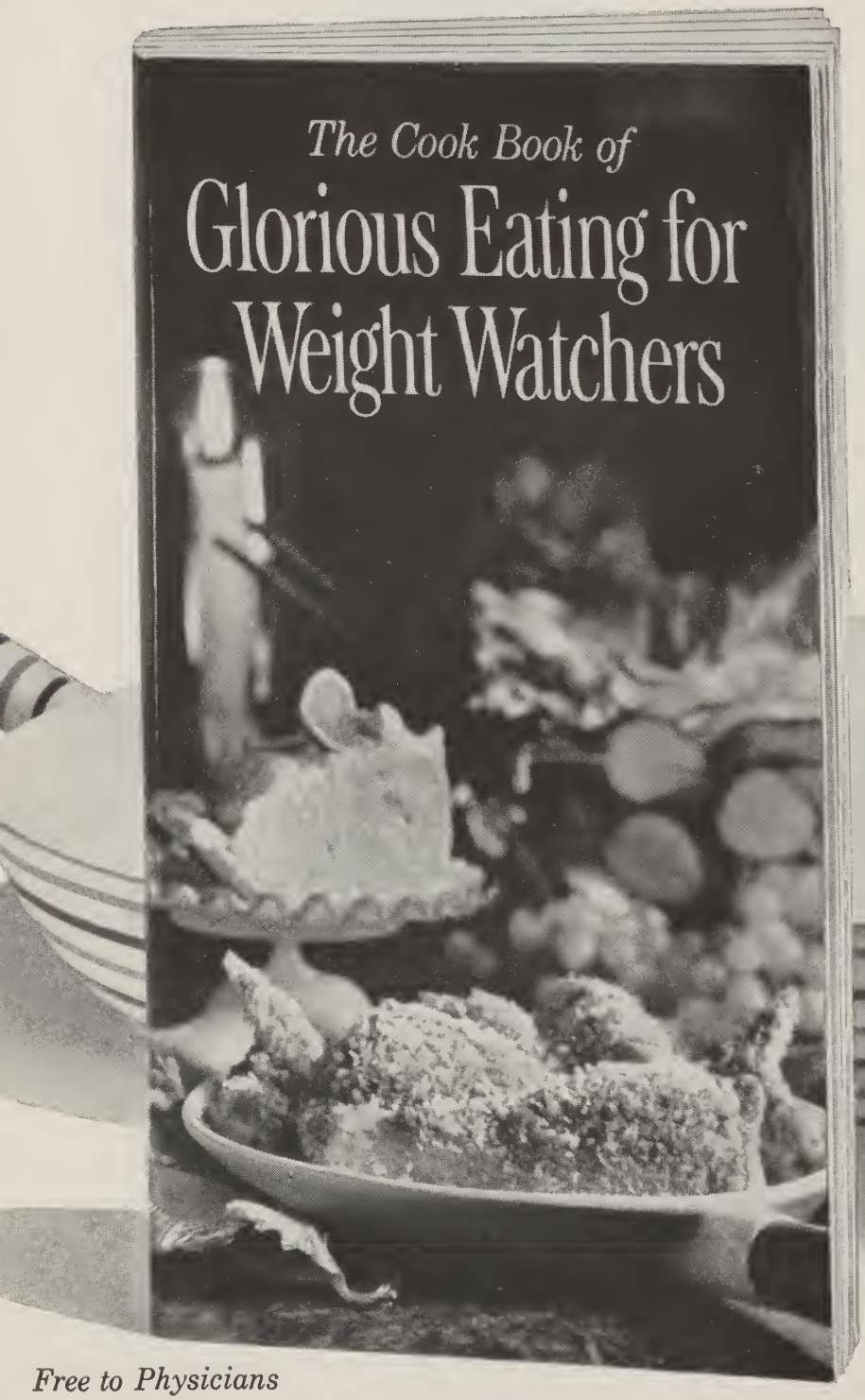
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Science for the World's Well-Being®

now available:
Antivert syrup

Each teaspoonful (5 cc.) contains 6.25 mg. meclizine HCl and 25 mg. nicotinic acid.

A REALISTIC AID TO PROPER WEIGHT MAINTENANCE

At Last...New Cook Book Designed





Free to Physicians

Menus fulfill the recommended dietary allowances of the Food & Nutrition Board of the National Research Counc

Prevent Overweight Through Better Eating Habits

Recipes and Menus with Satiety and Appetite Appeal in Mind

The Cook Book of Glorious Eating for Weight Watchers fills the long-felt need for a weight control plan that is workable for everybody in the family. Realistic regimens are built around good, natural, readily-available foods enhanced by delicious methods of preparation. In place of "fad diets" or tasteless formulas, it provides for truly appetizing meals. It teaches and encourages the development of the healthful eating habits that can prevent overweight, America's #1 Health Problem. This full-color cook book contains 100 pages—248 delicious recipes each with calorie counts. Complete menus are here at 3 calorie levels—1200, 1800, 2600. Calorie levels are related to *best* weights by sex, age, size and extent of activity.

Many diets fail because they are crash programs only temporary in effect. Other diets are unbearable because they are monotonous and tasteless.

The Wesson way is not a crash program. It offers calorie controlled menus with appetite appeal, variety and satiety in mind. They fulfill the recommended dietary allowances of the Food & Nutrition Board of the National Research Council.

All menus provide the proper amount of protein, carbohydrates, fat and the other essential nutrients. The principles of good nutrition are included to help the homemaker plan her own properly balanced, calorie controlled menus. With simple subtractions or additions to the same basic menu, each family member can be served delicious satisfying menus according to his individual needs.

Not a reducing manual. It should be explained that "The Cook Book of Glorious Eating for Weight Watchers" is a guide to the *prevention of obesity.* Its publication marks the first time that a food manufacturer like Wesson has taken so important a step to help combat this serious public health problem.

Copies for physicians. "The Cook Book of Glorious Eating for Weight Watchers" is being offered to the general public. If you would like a copy for yourself, together with forms to enable patients to obtain their own copies, please fill in coupon below.



Note: *Please do not confuse this booklet with the Cholesterol Depressant Diet Book, published by Wesson as an aid to physicians and* for professional distribution only. *The concept of the Cholesterol Depressant Diet Book stems from Wesson's value in cholesterol depressant diets. Where a vegetable (salad) oil is medically recommended for a cholesterol depressant regimen, poly-unsaturated Wesson is unsurpassed by any readily available brand.*

The Wesson People, Dept. M, 210 Baronne St., New Orleans 12, La.

Please send me my copy of "The Cook Book of Glorious Eating for Weight Watchers", plus two dozen order blanks for distribution to my patients.

_____ M.D.

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Poly-unsaturated **Wesson,** *the Pure Vegetable Oil, is Never Hydrogenated*

PUBLIC HEALTH PAGE

The New Division Of Radiological Health*

RUSSELL E. TEAGUE, M.D., M.P.H. *Commissioner of Health Commonwealth of Kentucky*

THE genesis of the Division of Radiological Health in July, 1960, was the result of growing concern over the potential health hazards associated with the multitude of ionizing radiation sources in the Commonwealth. The Division was initially designed for the purpose of evaluating radiation exposure sources such as X-ray units, medical and industrial radium-226, and radioactive environmental contaminants, and suggesting corrective measures for minimizing any exposure hazards associated with particular sources.

Recent progressive negotiations with the U.S. Atomic Energy Commission indicate that the scope of the Division will soon be expanded to include the licensing and regulation of byproduct, source, and special nuclear materials. These latter functions will follow the signing of an agreement between the Governor and the AEC in fulfillment of Public Law 86-373, and it is anticipated that Kentucky will be the first state to assume such responsibilities.

The ultimate goal of the Division is a so-called "total Radiation" program which will not discourage the increasing beneficial applications of ionizing radiation but rather encourage the practice of radiation safety. A total of almost 4,000 X-ray units is now being used in industry, medical arts, research, and miscellaneous applications in the Commonwealth. Contrasted to this, there are about 100 AEC licensees who use radioisotopes in most of these same fields.

Although radium-226 is commonly used in medical therapy and various static eliminator devices, there are no reliable estimates as to its exact quantity or distribution in Kentucky. Most of the radioactive mixed fission product contaminants in our environment have had their origin in the test detonations of nuclear and thermonuclear weapons. Both stratospheric and tropospheric bomb-produced fallout have caused the widespread distribution of these materials in air, surface water, and biota. Fortunately the level of radioactivity is usually very low, and the average yearly exposure of our population is probably no more than 5% of that which their genetic constitution is subjected to from cosmic rays and other sources of radiation in nature.

The X-Ray Problem

Many X-ray units in Kentucky have insufficient filtration and improper collimation. Insufficient filtration simply means that an inadequate number of aluminum filters have been placed in the path of the X-ray beam to filter out the "soft" X-rays. Superficial layers of an object placed in an unfiltered or partially filtered beam tend to absorb and scatter this low energy radiation.

In diagnostic radiography these "soft" X-rays usually do not contribute to the radiographic image on the film, and they may be needlessly absorbed by the skin and underlying tissues and scattered to other portions of the body. If a condition of improper collimation exists, the X-ray beam field size is usually much larger than necessary for carrying out a desired X-ray procedure. An excessive beam field area increases the probability of unnecessary exposure to all persons involved in the particular application.

As a general rule, only a radiological survey can accurately ascertain conditions of filtration and collimation before simple corrective steps may be taken. While a rather complete radiological survey normally consumes several hours of labor by a health physicist or a radiation physicist using intricate instrumentation, recent advances in survey techniques show promise of drastic reduction in personnel, instrument, and time requirements.

An example of a new technique of surveying dental X-ray units is the "Surpak" which was developed by the U.S. Public Health Service. Each "Surpak" is a large envelope containing a sheet of X-ray film and an aluminum step-wedge.

The Division of Rediological Health, in cooperation with the Division of Dental Health, the Kentucky

(Continued on Page 423)

**Article prepared by Morris L. Martin, Director, Division of Radiological Health.*

ANNOUNCING—
SPECIFICALLY FOR
INFECTIONS DUE TO
"RESISTANT" STAPHYLOCOCCI

AN ENTIRELY NEW SYNTHETIC
"STAPH-CIDAL" PENICILLIN

Staphcillin™

sodium dimethoxyphenyl penicillin
FOR INJECTION

UNIQUE—BECAUSE IT
RETAINS ANTIBACTERIAL
ACTIVITY IN THE PRESENCE OF
STAPHYLOCOCCAL PENICILLINASES
WHICH INACTIVATE
OTHER PENICILLINS

Bristol™

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NEW SYNTHETIC PENICILLIN FOR "RESISTANT" STAPH

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OFFICIAL PACKAGE CIRCULAR
November, 1960

STAPHCILLIN™

(sodium dimethoxyphenyl penicillin)
For Injection

DESCRIPTION

STAPHCILLIN is a unique new synthetic parenteral penicillin produced by Bristol Laboratories for the specific treatment of staphylococcal infections due to resistant organisms. Its uniqueness resides in its property of resisting inactivation by staphylococcal penicillinase. It is active against strains of staphylococci which are resistant to other penicillins.

Each dry filled vial contains: 1 Gm. STAPHCILLIN (sodium dimethoxyphenyl penicillin), equivalent to 900 mg. dimethoxyphenyl penicillin activity.

INDICATIONS

STAPHCILLIN is recommended as specific therapy only in infections due to strains of staphylococci resistant to other penicillins, e.g.:

Skin and soft tissue infections: cellulitis, wound infections, carbuncles, pyoderma, furunculosis, lymphangitis and lymphadenitis.

Respiratory infections: staphylococcal lobar or bronchopneumonia, and lung abscesses combined with indicated surgical treatment.

Other infections: staphylococcal septicemia, bacteremia, acute or subacute endocarditis, acute osteomyelitis and enterocolitis.

Infections due to penicillin-sensitive staphylococci, streptococci, pneumococci and gonococci should be treated with Syncillin® or parenteral penicillin G rather than STAPHCILLIN. Treponemal infections should be treated with parenteral penicillin G.

DOSAGE AND ADMINISTRATION

STAPHCILLIN is well tolerated when given by deep intragluteal or intravenous injection.

As is the case with other antibiotics, the duration of therapy should be determined by the clinical and bacteriological response of the patient. Therapy should be continued for at least 48 hours after the patient has become afebrile, asymptomatic and cultures are negative. The usual duration has been 5-7 days.

Intramuscular route: The usual adult dose is 1 Gm. every 4 or 6 hours. Infants' and children's dosage is 25 mg. per Kg. (approximately 12 mg. per pound) every 6 hours.

Intravenous route: 1 Gm. every 6 hours using 50 ml. of sterile saline solution at the rate of 10 ml. per minute.

**Warning:* Solutions of STAPHCILLIN and kanamycin should not be mixed, as they rapidly inactivate each other. Data on the results of mixing STAPHCILLIN with other antibiotics are being accumulated.

DIRECTIONS FOR RECONSTITUTION

Add 1.5 ml. sterile distilled water or normal saline to a 1 Gm. vial and shake vigorously. Withdraw the clear, reconstituted solution (2.0 ml.) into a syringe and inject. The reconstituted solution contains 500 mg. of STAPHCILLIN per ml. Reconstituted solutions are stable for 24 hours under refrigeration.

For intravenous use, dilute the reconstituted dose in 50 ml. of sterile saline and inject at the rate of 10 ml. per minute.

*This statement supersedes that in the Official Package Circulars dated September and/or October, 1960.

(continued)

Official Package Circular
(continued)

MICROBIOLOGICAL AND PHARMACOLOGICAL PROPERTIES

In vitro studies show that STAPHCILLIN is a bactericidal penicillin with activity against staphylococci resistant to penicillin G. Strains of staphylococci so far tested have been sensitive to STAPHCILLIN *in vitro* at concentrations of 1-6 mcg. per ml. These levels are readily attained in the blood and tissues by administration of STAPHCILLIN at the recommended dosage. This unique attribute is probably due to the fact that STAPHCILLIN is stable in the presence of staphylococcal penicillinase. STAPHCILLIN also resists degradation by *B. cereus* penicillinase. The antimicrobial spectrum of STAPHCILLIN with regard to other microorganisms is qualitatively similar to that of penicillin G; but considerably higher concentrations of STAPHCILLIN are required for bactericidal activity than is the case with penicillin G.

STAPHCILLIN is rapidly absorbed after intramuscular injection. Peak blood levels (6-10 mcg./ml. on the average after a 1.0 Gm. dose) are attained within 1 hour; and then progressively decline to less than 1 mcg. over a 4 to 6 hour period. It is poorly absorbed from the gastrointestinal tract. STAPHCILLIN is rapidly excreted by the kidney.

As shown by animal studies, STAPHCILLIN is readily distributed in body tissues after intramuscular injection. Of the tissues studied, highest concentrations are reached in the kidney, liver, heart and lung in that order; the spleen and muscles show lower concentrations of the antibiotic. STAPHCILLIN diffuses into human pleural and prostatic fluids, but its diffusion into the spinal fluid has not yet been completely studied. However, one patient with meningitis showed a significant concentration in his spinal fluid while on STAPHCILLIN therapy.

Toxicity studies with STAPHCILLIN and penicillin G in animals show that they have approximately the same low order of toxicity.

Certain staphylococci can be made resistant to STAPHCILLIN in the laboratory, but this resistance is not related to their penicillinase production. During the clinical trials, no STAPHCILLIN-resistant strains of staphylococci were observed or developed; the possibility of the emergence of such strains in the clinical setting awaits further observation.

PRECAUTIONS

During the clinical trials, several mild skin reactions, e.g., itching, papular eruption and erythema were observed both during and after discontinuance of STAPHCILLIN therapy. Patients with histories of hay fever, asthma, urticaria and previous sensitivity to penicillin are more likely to react adversely to the penicillins. It is important that the possibility of penicillin anaphylaxis be kept in mind. Epinephrine and the usual adjuvants (antihistamines, corticosteroids) should be available for emergency treatment. Because of the resistance of STAPHCILLIN to destruction by penicillinase, parenteral *B. cereus* penicillinase may not be effective for the treatment of allergic reactions. Information with regard to cross-allergenicity between penicillin G, penicillin V, phenethicillin (Syncillin) and STAPHCILLIN is not available at present. If superinfection due to Gram-negative organisms or fungi occurs during STAPHCILLIN therapy, appropriate measures should be taken.

SUPPLY

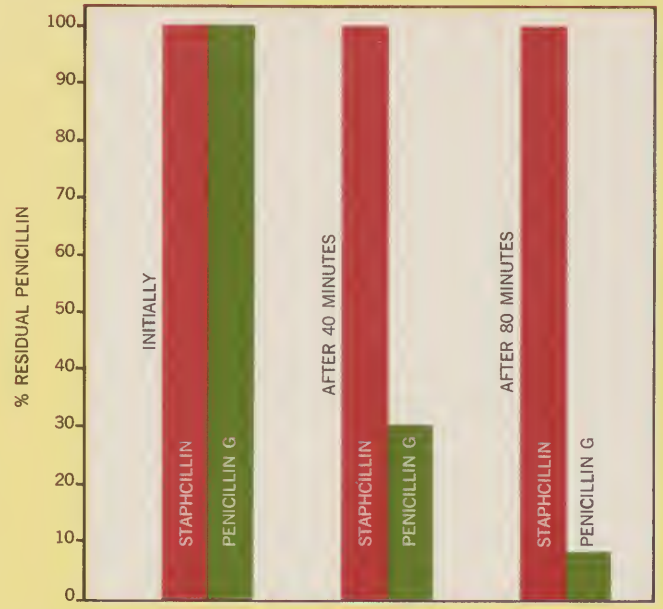
List 79502 — 1.0 Gm. dry filled vial.

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Division of Bristol-Myers Company

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UNIQUE SYNTHETIC "STAPH-CIDAL" PENICILLIN

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In the presence of staphylococcal penicillinase, STAPHCILLIN remained active and retained its antibacterial action. By contrast, penicillin G was rapidly destroyed in the same period of time. *(After Gourevitch et al., to be published)*

Specifically for "resistant" staph...

Staphcillin™

sodium dimethoxyphenyl penicillin
FOR INJECTION

The failure of staphylococcal infections to respond to penicillin therapy is attributed to the penicillin-destroying enzyme, penicillinase, produced by the invading staphylococcus.

Unlike other penicillins:

1 STAPHCILLIN is effective because it retains its antibacterial activity despite the presence of staphylococcal penicillinase.

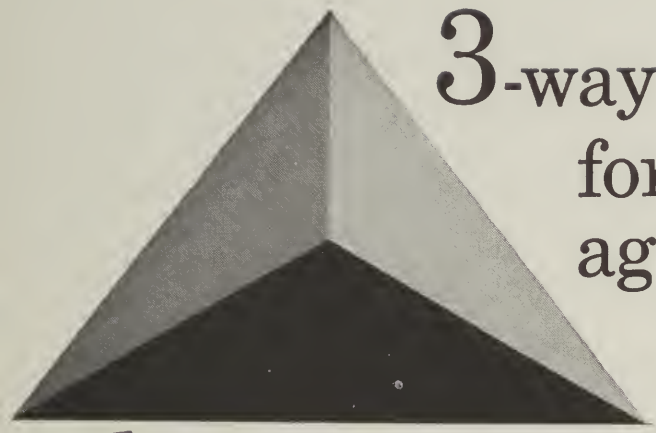
2 The clinical effectiveness of STAPHCILLIN has been confirmed by dramatic results in a wide variety of infections due to "resistant" staphylococci, many of which were serious and life-threatening.

Like other penicillins:

STAPHCILLIN has no significant systemic toxicity. It is well tolerated locally, and pain or irritation at the injection site is comparable to that following the injection of penicillin G. *In occasional cases, typical penicillin reactions may be experienced.*

PROFESSIONAL INFORMATION SERVICE — The attached Official Package Circular provides complete information on the indications, dosage, and precautions for the use of STAPHCILLIN. If you desire additional information concerning clinical experiences with STAPHCILLIN, the Medical Department of Bristol Laboratories is at your service. You may direct your inquiries via collect telephone call to New York, PLaza 7-7061, or by mail to Medical Department, Bristol Laboratories, 630 Fifth Ave., N. Y. 20, N. Y.

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3-way support for the aging patient...

ASSISTS PROTEIN UPTAKE
IMPROVES MENTAL OUTLOOK
AIDS NUTRITIONAL INTAKE

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Each capsule contains: Ethinyl Estradiol 0.01 mg. • Methyl Testosterone 2.5 mg. • d-Amphetamine Sulfate 2.5 mg. • Vitamin A (Acetate) 5,000 U.S.P. Units • Vitamin D 500 U.S.P. Units • Vitamin B_{12} with AUTRINIC® Intrinsic Factor Concentrate 1/15 U.S.P. Unit (Oral) • Thiamine Mononitrate (B_1) 5 mg. • Riboflavin (B_2) 5 mg. • Niacinamide 15 mg. • Pyridoxine HCl (B_6) 0.5 mg. • Calcium Pantothenate 5 mg. • Choline Bitartrate 25 mg. • Inositol 25 mg. • Ascorbic Acid (C) as Calcium Ascorbate 50 mg. • l-Lysine Monohydrochloride 25 mg. • Vitamin E (Tocopherol Acid Succinate) 10 Int. Units • Rutin 12.5 mg. • Ferrous Fumarate (Elemental iron, 10 mg.) 30.4 mg. • Iodine (as KI) 0.1 mg. • Calcium (as $CaHPO_4$) 35 mg. • Phosphorus (as $CaHPO_4$) 27 mg. • Fluorine (as CaF_2) 0.1 mg. • Copper (as CuO) 1 mg. • Potassium (as K_2SO_4) 5 mg. • Manganese (as MnO_2) 1 mg. • Zinc (as ZnO) 0.5 mg. • Magnesium (MgO) 1 mg. • Boron (as $Na_2B_4O_7.10H_2O$) 0.1 mg. Bottles of 100, 1000.

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MEMBER:
National Geriatrics Society
American Hospital Association
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Licensed and Approved by State of Ky.

Active medical staff of six physicians. Physicians available at all hours. 24 hour efficient and cheerful nursing care WITH SPECIAL EMPHASIS ON MAKING EACH PATIENT FEEL LOVED, WANTED AND IMPORTANT.

Special diets prepared and tray service to all rooms at no extra charge.

Diversional activities, physio-therapy treatments, rehabilitation program and emergency facilities available.

Adequate shade trees, ramps, also day room with abundance of flowers, television.

PRIVATE, SEMI-PRIVATE AND WARD ACCOMMODATIONS AVAILABLE. Private and semi-private rooms with intercommunication, beautifully decorated and furnished, beds equipped with Trendelenburg springs and innerspring mattresses.

Insulated brick and block structure, heated in winter by "Selectemp" Modulated Steam Heat with filtered air for maximum comfort and safety (each room having thermostatic even-heat control with its own circulating air unit).

Protected throughout with automatic fire detection and alarm system.

Cares for men or women, nursing or boarding care cases, bedridden or ambulatory. Admits some mildly senile, nervous and neurotic patients but accepts no alcoholics or drug addiction cases.

REASONABLE RATES

IRA O. WALLACE, Administrator

MARGARET KELLY, R. N., Director of Nurses



in sulfa therapy...

RELEASE YOUR PATIENT FROM Q.I.D. DOSAGE

just one tablet of Midicel provides continuous, effective blood levels for 24 hours

Because many patients need take only 1 tablet daily, therapy with MIDICEL is convenient and economical. It is also advantageous since the possibility of omitted doses is reduced. Rapidly absorbed and slowly excreted, MIDICEL assures dependable bacteriostatic action in urinary tract infections, certain respiratory infections, bacillary dysenteries, as well as surgical and soft-tissue infections caused by sulfonamide-sensitive organisms. And with MIDICEL, there is little likelihood of crystalluria because of its high solubility and low dosage.

MIDICEL (sulfamethoxypyridazine, Parke-Davis), 3-sulfanilamido-6-methoxypyridazine. Tablets of 0.5 Gm.; Suspension, each cc. containing 50 mg. of sulfamethoxypyridazine as the N'-acetyl derivative. *Indications:* Gram-negative and gram-positive infections such as urinary tract, respiratory, and soft-tissue infections and bacillary dysenteries. *Dosage:* Orally once a day until asymptomatic for 48 to 72 hours. Adults:—1 Gm. initially, followed by 0.5 Gm. daily thereafter or 1 Gm. every other day. In severe infections, not to exceed 2 Gm. the first day, then 0.5 to 1.5 Gm. daily according to weight of patient and severity of infection. Children:—30 mg. per Kg. the first day, then 15 mg. per Kg. daily. In severe infections, up to 50 mg. per Kg. initially, then 25 mg. per Kg. daily. Total dose in children, however, should not exceed lower dosage limits for adults. *Precautions:* Continue daily doses higher than 0.5 Gm. no longer than three to five days without checking for blood levels above therapeutic range. Maintain adequate fluid intake during therapy and for 48 to 72 hours afterward. Until further definitive information is available, MIDICEL, in common with all sulfonamides, is contraindicated in the premature and newborn infant. Contraindicated in patients with a history of sulfa sensitivity. MIDICEL is not recommended for meningococcal infections. *Side Effects:* Anorexia and lassitude may occur as may reactions such as drug fever, rash, and headache, all of which are indications for discontinuing the drug. Leukopenia has been reported. Periodic blood counts are advised. Patients with impaired renal function should be followed closely since excessive accumulation may occur. *Available:* Quarter-scored tablets of 0.5 Gm., bottles of 24, 100, and 1,000.

60161

Midicel®

(sulfamethoxypyridazine, Parke-Davis)

and for children...Midicel Acetyl Suspension (N¹ acetyl sulfamethoxypyridazine, Parke-Davis) • delicious butterscotch flavor • only one dose a day

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twin g. i. symptoms?

pain
spasm

twin g. i. problems?

hyperacidity
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prescribe "twin action"

ALUCEN*

new anticholinergic-antacid chewable tablets

for superior adjunctive therapy of *peptic ulcer*... superior relief of *gastritis* due to gastric hyperacidity and g.i. hypermotility

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The Chicago Committee on Trauma of the American College of Surgeons has set April 19-22 for its fifth Postgraduate Course on Fractures and Other Trauma at the John B. Murphy Memorial Auditorium, 50 East Erie Street, Chicago. The course will be presented by a faculty of 11 guest speakers and teachers prominent in the fields of trauma from the five medical schools and chiefs of services from leading Chicago hospitals. The registration fee will be $75. Inquiries should be addressed to John J. Fahey, M.D., Chairman, 1791 W. Howard Street, Chicago 26, Ill.

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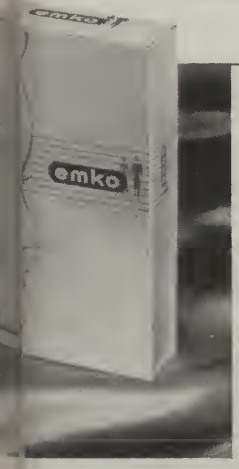
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PUBLIC HEALTH PAGE

(Continued from Page 408)

Dental Association, and the U.S. Public Health Service, is planning to conduct a "Surpak" survey of all dental X-ray units in the state during April, May, and June. After the dentist receives a "Surpak" in the mail, he will expose it for several seconds under his X-ray unit and then mail it back to the Division of Radiological Health. Not only will conditions of collimation and filtration be determined by this method, but the roentgen dose-rate and the shielding integrity of the X-ray tube housing will also be established.

In connection with the "Surpak" survey, a registry of all dental X-ray units will be accomplished. A registration form with information concerning each unit's owner, manufacturer, and model number will be filed with the Division, and a state registration number will then be assigned to each machine.

New Regulations For Radioisotopes

A new series of "RH" regulations, which relate to the Division's forthcoming assumption of AEC radioisotope licensing and regulatory authority, are now being prepared for review and adoption by the State Board of Health. These proposed regulations are quite comparable in content to existing AEC regulations, and the only major difference is the modified format found in the "RH" regulations. Because these regulations must necessarily be compatible with existing federal regulations, Division licensees should encounter no difficulty when entering into transactions involving acquisition or transfer of radioisotopes with AEC licensees in other states.

WASHINGTON NEWS DIGEST

(Continued from Page 344)

facilities and resources to include other medical facilities.

Federal grants also would be authorized to help finance studies, experiments and demonstrations by states and other nonfederal agencies for development of new or improved methods of providing health services outside hospitals, particularly for chronically ill or aged persons.

The AMA found "much to applaud" in Kennedy's over-all health program, but stood fast in opposing the proposal to provide elderly persons with health care through the Social Security System. F. J. L. Blasingame, M.D., executive vice-president of the AMA, said:

"We support the broad principles and the general goals of the President's program, but we cannot support his proposal for hospitalization and nursing home care for persons over 65 under Social Security.

"In fact, after studying this section of the President's plan, the AMA more strongly than ever reaffirms its support of the Kerr-Mills law."



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1. Youmans, J. B.: Am. J. Med. 25:659 (Nov.) 1958

cardiac diseases "Who can say, for example, whether the patient chronically ill with myocardial failure may not have a poorer myocardium because of a moderate deficiency in the vitamin B-complex? Something is known of the relationship of vitamin C to the intercellular ground substance and repair of tissues. One may speculate upon the effects of a deficiency of this vitamin, short of scurvy, upon the tissues in chronic disease."[2] 2. Kampmeier, R. H.: Am. J. Med. 25:662 (Nov.) 1958.

arthritis "It is our practice to prescribe a multiple vitamin preparation to patients with rheumatoid arthritis simply to insure nutritional adequacy . . ."[3]
3. Fernandez-Herlihy, L: Lahey Clinic Bull. 11:12 (July-Sept.) 1958.

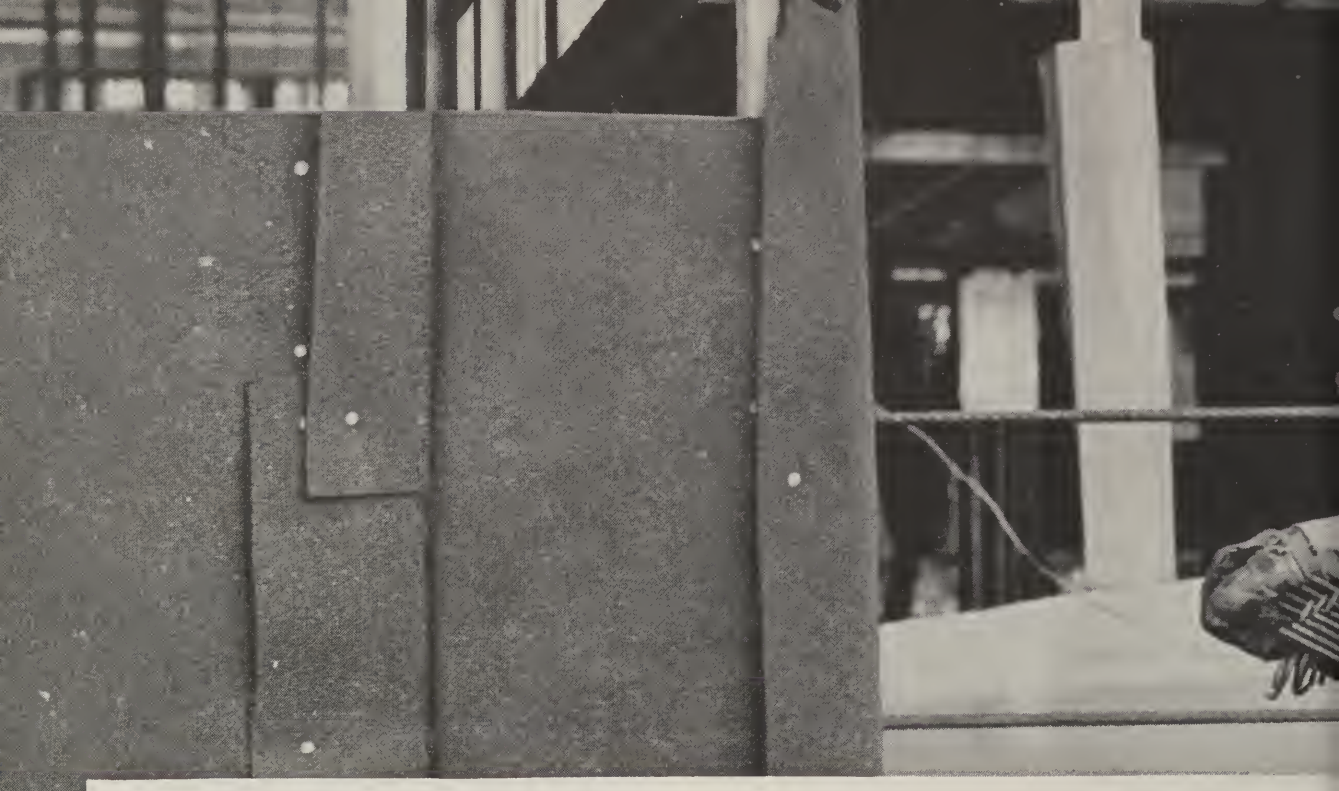
digestive diseases Symptoms attributable to B-vitamin deficiency are commonly observed in patients on peptic ulcer diets.[4] Daily administration of therapeutic vitamins to patients with hepatitis and cirrhosis is recommended by the National Research Council.[5] 4. Sebrell, W. H.: Am. J. Med. 25:673 (Nov.) 1958. 5. Pollack, H., and Halpern, S. L.: Therapeutic Nutrition, National Academy of Sciences and National Research Council, Washington, D. C., 1952, p. 57.

degenerative diseases "Studies by Wexberg, Jolliffe and others have indicated that many of the symptoms attributed in the past to senility or to cerebral arteriosclerosis seem to respond with remarkable speed to the administration of vitamins, particularly niacin and ascorbic acid. These facts indicate that the vitamin reserve of aging persons is lowered, even to the danger point, more than is the case in the average American adult."[6] 6. Overholser, W., and Fong, T.C.C. in Stieglitz, E. J.: Geriatric Medicine, 3rd edition, J. B. Lippincott, Philadelphia, 1954, p. 264.

infectious diseases Infections cause a lowering of ascorbic acid levels in the plasma; and the absorption of this vitamin is reduced in diarrheal states.[7] 7. Goldsmith, G A.: Conference on Vitamin C. The New York Academy of Sciences, New York City, Oct. 7 and 8, 1960. Reported in: Medical Science 8:772 (Dec.10) 1960.

diabetes Diabetics, like all patients on restricted diets, require an extra source of vitamins.[8] "Rigidly limiting the bread intake of the diabetic patient automatically eliminates a large amount of thiamin from the diet. . . . There is some evidence of interference with normal riboflavin utilization during catabolic episodes."[9]
8. Duncan G. G.: Diseases of Metabolism 4th edition W. B. Saunders, Philadelphia, 1959, p. 812. 9. Pollack, H.: Am. J. Med. 25:708 (Nov.) 1958.

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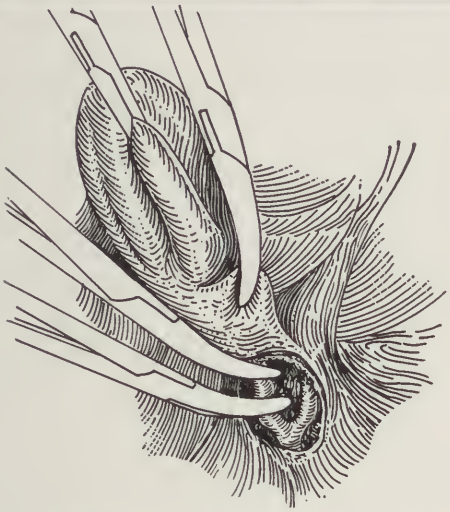
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Source: Farris, J. M., and Smith, G. K.: M. Clin. North America *43*:1133 (July) 1959.

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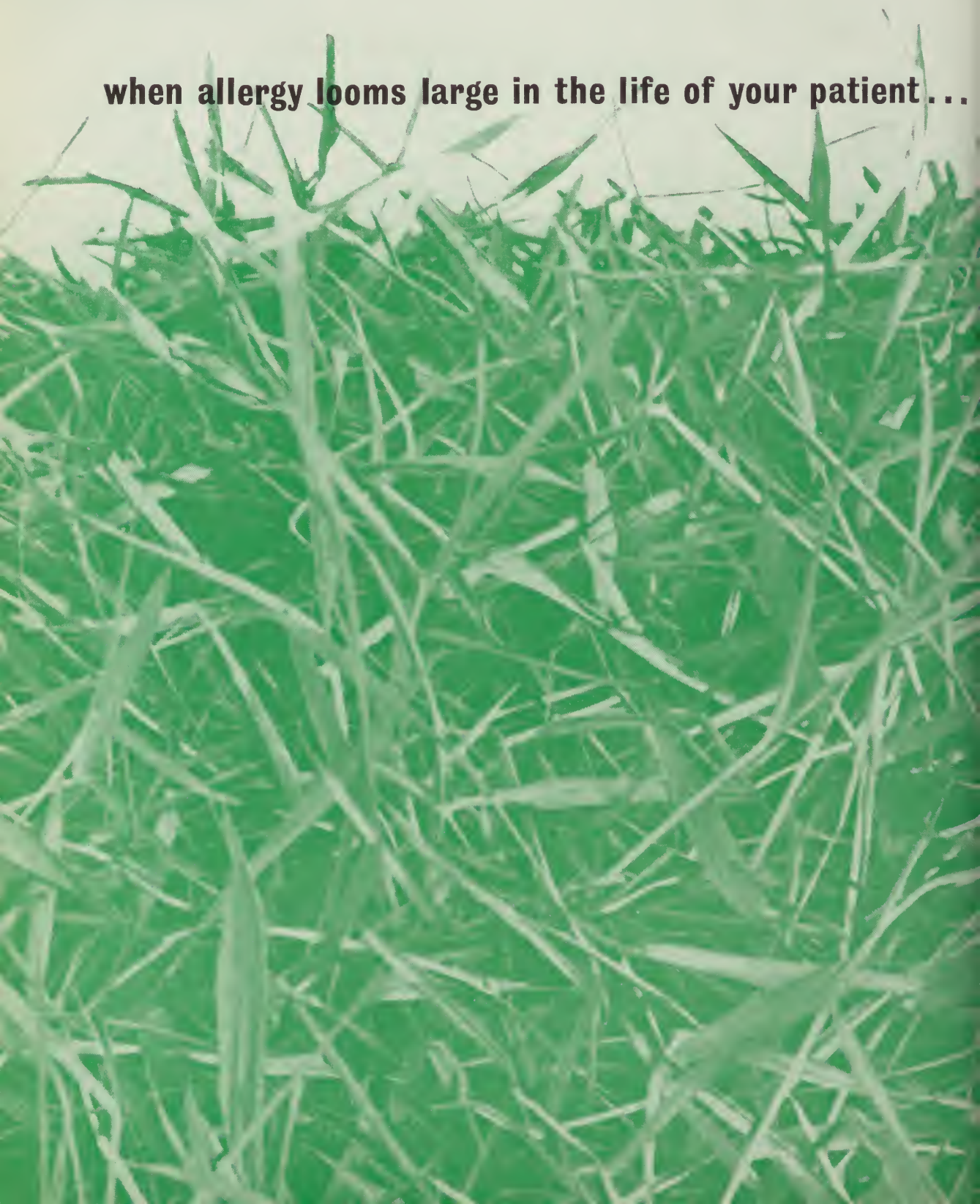
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Pastgraduate Offerings far Area Listed Thraugh August 500
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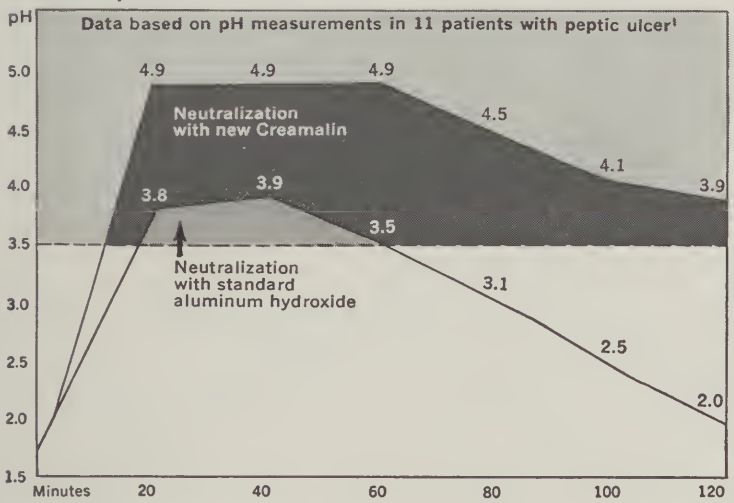
REGULAR FEATURES

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At the site of peptic ulcer



Following determination of basal secretion, intragastric pH was continuously determined by means of frequent readings over a two-hour period.



neutralization is much faster and twice as long with

New CREAMALIN® ANTACID TABLETS

New proof in vivo[1] of the much greater efficacy of new Creamalin tablets over standard aluminum hydroxide has now been obtained. Results of comparative tests on patients with peptic ulcer, measured by an intragastric pH electrode, show that new Creamalin neutralizes acid from 40 to 65 per cent faster than the standard preparation. This neutralization (pH 3.5 or above) is maintained for approximately one hour longer.

New Creamalin provides virtually the same effects as a liquid antacid[2] with the convenience of a tablet.

Nonconstipating and pleasant-tasting, new Creamalin antacid tablets will not produce "acid rebound" or alkalosis.

Each new Creamalin antacid tablet contains 320 mg. of specially processed, highly reactive, short polymer dried aluminum hydroxide gel (stabilized with hexitol) with 75 mg. of magnesium hydroxide. Minute particles of the powder offer a vastly increased surface area for quicker and more complete acid neutralization.

Dosage: Gastric hyperacidity — from 2 to 4 tablets as necessary. Peptic ulcer or gastritis — from 2 to 4 tablets every two to four hours. Tablets may be chewed, swallowed whole with water or milk, or allowed to dissolve in the mouth. **How supplied:** Bottles of 50, 100, 200 and 1000.

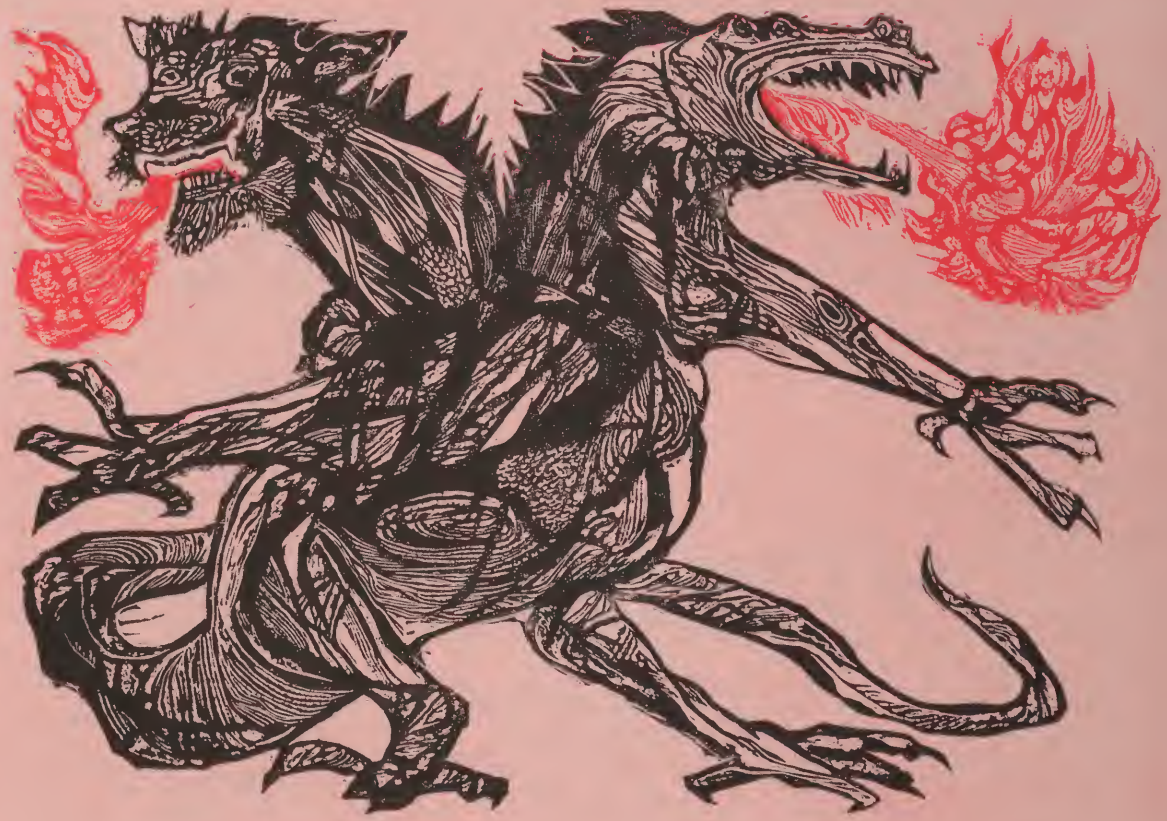
1. Data in the files of the Department of Medical Research, Winthrop Laboratories. 2. Hinkel, E. T., Jr.; Fisher, M. P., and Tainter, M. L.: **J. Am. Pharm. A.** (Scient. Ed.) 48:384, July, 1959.

Winthrop LABORATORIES
New York 18, N. Y.

for peptic ulcer ■ gastritis ■ gastric hyperacidity

1467M

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A dual-acting skeletal muscle relaxant-analgesic, combining the clinically proven relaxant action of ROBAXIN with the time-tested pain relieving action of aspirin.

Each **ROBAXISAL** Tablet contains:
ROBAXIN (methocarbamol Robins) 400 mg. Acetylsalicylic acid (5 gr.)..... 325 mg.
U.S. Pat. No. 2770649
Supply: Bottles of 100 and 500 pink-and-white laminated tablets.

Or ROBAXISAL®-PH (ROBAXIN with Phenaphen®) — when anxiety is associated with painful skeletal muscle spasm.

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ROBAXIN (methocarbamol Robins) 400 mg. Acetylsalicylic acid ..... 81 mg.
Phenacetin 97 mg. Hyoscyamine sulfate 0.016 mg. Phenobarbital (1/8 gr.) 8.1 mg.
Supply: Bottles of 100 and 500 green-and-white laminated tablets.

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Making today's medicines with integrity ... seeking tomorrow's with persistence.





1¼ Grs. Ea.
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Living up to a family tradition

There are probably certain medications which are special favorites of yours, medications in which you have a particular confidence.

Physicians, through ever increasing recommendation, have long demonstrated their confidence in the uniformity, potency and purity of Bayer Aspirin, the world's first aspirin.

And like Bayer Aspirin, Bayer Aspirin for Children is quality controlled. No other maker submits aspirin to such thorough quality controls as does Bayer. This assures uniform excellence in both forms of Bayer Aspirin.

You can depend on Bayer Aspirin for Children for it has been conscientiously formulated to be the best tasting aspirin ever made and to live up to the Bayer family tradition of providing the finest aspirin the world has ever known.

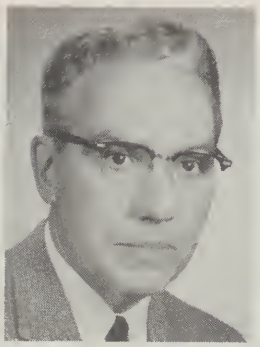
Bayer Aspirin for Children—1¼ grain flavored tablets—Supplied in bottles of 50.

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Dr. Gilbert
Vice-President—Western

President's Page*

Let's All Pull Together!

IN these turbulent times, when the future of medicine and our entire way of living is at stake, it is of utmost importance that there be complete coopcration among doctors. Each of us should try to understand the problems facing the profession.

Now is the time for every doctor to read all the articles concerning thc Kerr-Mills bill as well as the newly proposed King bill and to be able to properly evaluate and discuss them. This is a crucial period, one in which wc must all stand shoulder to shoulder and present a solid front.

It has been said that almost every patient likes his own doctor, but does not have the samc feeling toward the rest of the medical profcssion. It is difficult to believe that this is entirely true, but it should accentuate the need for working together, complimenting each other, and being careful of what we say about each other. So oftcn one little careless remark about another doctor might lead a patient or friend to believe that we do not respect each other; an entirely false idea, and one which is quickly accepted by the person who is looking for some excuse to downgrade thc profession. This does not mean, however, that we should not clean up our own ranks or should condone malpractice procedures.

It is very important that we all pull strongly together, after discussion among ourselves leads to acceptance of a solution by the majority. Our KSMA legislative committee is doing a wonderful job in compiling and presenting to us the important material concerning our future. It feels that now is the time for action by all of us. Be sure to read all the material this committee sends and not give it the wastebasket treatment.

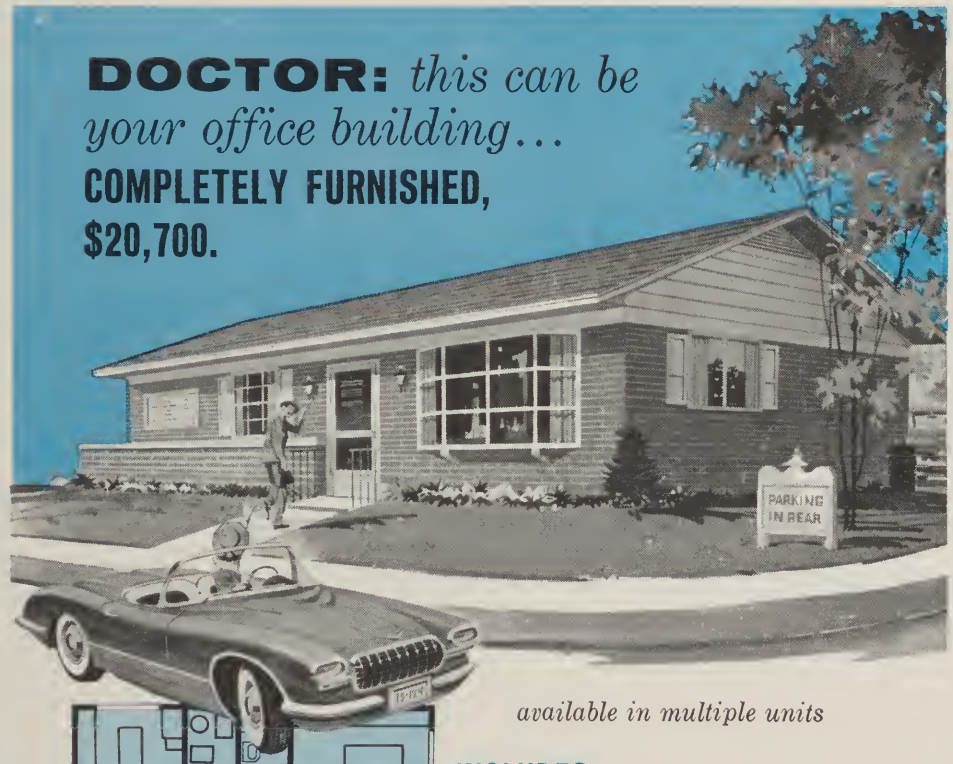
It was a distinct pleasure to hear Mr. Roger Fleming of the American Farm Bureau Federation, at the County Society Officers Conference, tell of the strong stand they were taking against federal controls, including the Social Security approach to socialized medicine. It was heartwarming to feel that most people are in favor of private enterprise and the family unit running the government, rather than eventual federal control of everything, including medicine. Let us continue to cooperate with our friends in all walks of life, particularly our coworkcrs in the field of medical care, to try to prevcnt the cxtension of federal control in any direction.

And remember—the proponents of Social Security medical aid and socialized medicine can lose many times in Congress, but we can lose only once. Do not devclop a defeatist attitude. All signs point toward victory if we continue to fight individually and collectively for our free enterprise type of government.

J. T. Gilbert, M.D.

**This is the fourth of a series of four guest articles written at the invitation of Richard G. Elliott, M.D., KSMA president.*

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"nutrition...present as a modifying or complicating factor in nearly every illness or disease state"[1]

1. Youmans, J. B.: Am. J. Med. 25:659 (Nov.) 1958

cardiac diseases "Who can say, for example, whether the patient chronically ill with myocardial failure may not have a poorer myocardium because of a moderate deficiency in the vitamin B-complex? Something is known of the relationship of vitamin C to the intercellular ground substance and repair of tissues. One may speculate upon the effects of a deficiency of this vitamin, short of scurvy, upon the tissues in chronic disease."[2] 2. Kampmeier, R. H.: Am. J. Med. 25:662 (Nov.) 1958.

arthritis "It is our practice to prescribe a multiple vitamin preparation to patients with rheumatoid arthritis simply to insure nutritional adequacy . . ."[3]
3. Fernandez-Herlihy, L: Lahey Clinic Bull. 11:12 (July-Sept.) 1958.

digestive diseases Symptoms attributable to B-vitamin deficiency are commonly observed in patients on peptic ulcer diets.[4] Daily administration of therapeutic vitamins to patients with hepatitis and cirrhosis is recommended by the National Research Council.[5] 4. Sebrell, W. H.: Am. J. Med. 25:673 (Nov.) 1958. 5. Pollack, H., and Halpern, S. L.: Therapeutic Nutrition, National Academy of Sciences and National Research Council, Washington, D. C., 1952, p. 57.

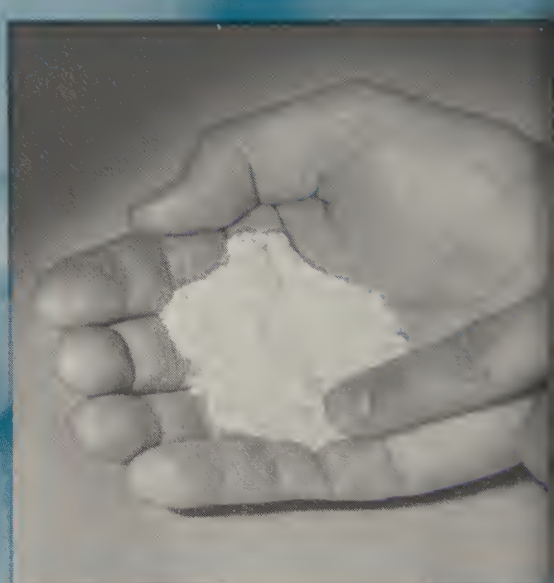
degenerative diseases "Studies by Wexberg, Jolliffe and others have indicated that many of the symptoms attributed in the past to senility or to cerebral arteriosclerosis seem to respond with remarkable speed to the administration of vitamins, particularly niacin and ascorbic acid. These facts indicate that the vitamin reserve of aging persons is lowered, even to the danger point, more than is the case in the average American adult."[6] 6. Overholser, W., and Fong, T.C.C. in Stieglitz, E. J.: Geriatric Medicine, 3rd edition, J. B. Lippincott, Philadelphia, 1954, p. 264.

infectious diseases Infections cause a lowering of ascorbic acid levels in the plasma; and the absorption of this vitamin is reduced in diarrheal states.[7] 7. Goldsmith, G A.: Conference on Vitamin C. The New York Academy of Sciences, New York City, Oct. 7 and 8, 1960. Reported in: Medical Science 8:772 (Dec.10) 1960.

diabetes Diabetics, like all patients on restricted diets, require an extra source of vitamins.[8] "Rigidly limiting the bread intake of the diabetic patient automatically eliminates a large amount of thiamin from the diet. . . . There is some evidence of interference with normal riboflavin utilization during catabolic episodes."[9]
8. Duncan G. G.: Diseases of Metabolism 4th edition W. B. Saunders, Philadelphia, 1959, p. 812. 9. Pollack, H.: Am. J. Med. 25:708 (Nov.) 1958.

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demonstrating.



1 place the foam in your hand (one applicator full). Note the volume . . . plenty for an effective block.

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THESE PHOTOS SHOW HOW EMKO'S BLOCK OF FOAM SEALS THE CERVICAL OS ... AND HOW IT VANISHES COMPLETELY WITHOUT DOUCHING. ONLY EMKO FOAM, BECAUSE OF ITS VIRTUAL WEIGHTLESSNESS, CAN PROVIDE THIS DIAPHRAGM-LIKE PROTECTION ... AND STILL PERMIT NORMAL MARITAL RELATIONS WITH FULL PARTNER COOPERATION.

a proven spermicide ...

The total surface area of each bubble of Emko Vaginal Foam contains the proven spermicidal combination of Nonyl phenoxy polyoxyethylene ethanol 8.0% and Benzethonium Chloride 0.2%. As the sperm attempts to penetrate the block of foam, its erratic course exposes it constantly to the large contact area created by the bubbles. Thus, Emko Vaginal Foam assures maximum spermicidal exposure ... with a minimum weight of material.

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3 now, rub your hands together. Work the foam into your skin just as you would a fine hand lotion.

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For the irritable G.I. tract

Milpath acts quickly to suppress hypermotility, hypersecretion, pain and spasm, and to allay anxiety and tension with minimal side effects.

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MILPATH-400—Yellow, scored tablets of 400 mg. Miltown (meprobamate) and 25 mg. tridihexethyl chloride.
Bottle of 50.

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In periodic patient follow-up, you really come to appreciate the meaning of "True-to-Dial" accuracy with the G-E Patrician "200" combination. Film comparison is easier because of guaranteed consistent x-ray output. Performance holds predictably from range to range . . . even from one G-E unit to another! And with it you get so many more Patrician features: full-size 81" tilting table . . . independent tubestand . . . counterbalanced, not counterpoised, fluoroscopic screen or spot-film device . . . radiation confined to screen area by automatic shutter limiting device . . . economy of purchase and operation. **You can rent the Patrician.** G-E Maxiservice® plan provides an attractive alternative to outright purchase. Included, for a convenient monthly fee, are installation, maintenance, parts, tubes, insurance, local taxes. Contact your G-E x-ray representative listed below for details.

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THE INSURANCE PAGE



Plain Talk About Tomorrow

THE imminent Congressional battle over President Kennedy's proposal to provide hospital and nursing care for the aged through Social Security poses an obvious and urgent challenge to the medical profession. To put it as simply as possible, medicine is challenged—*now*—to deliver a solid, realistic program of prepaid medical care for the people of the United States through its own voluntary mechanisms, *or* to have such a program organized and imposed upon us by our national government.

To fancy that if we only ignore this threat it will go away is to delude ourselves and to forfeit what may be our last opportunity to preserve private enterprise in medical practice. And it would be incredibly naive to suppose that organized medicine and its consecutive business allies can decisively turn back the tide that's running today without offering a clearly preferable substitute program.

What have we to offer? Why not Blue Shield? For, despite the fact that many Blue Shield Plans are inadequate in their scope of coverage and unrealistic in the degree of assurance of complete protection that they offer the patient, nevertheless Blue Shield has already enlisted the voluntary support of more than a quarter of all the people in the United States.

Blue Shield is the only major prepayment program responsible and responsive to the medical profession, the only major program free of commercial control, the only major program that is creditably identified in the popular mind with the private physician.

Even more important is the fact that Blue Shield has found the formula for providing medical services on terms that have proved eminently satisfactory both to the patient and the doctor. It is safe to say that if all Blue Shield Plans were offering as good a program as the best of them do today, private medicine could meet the challenge of the immediate future with reasonable confidence in the public decision.

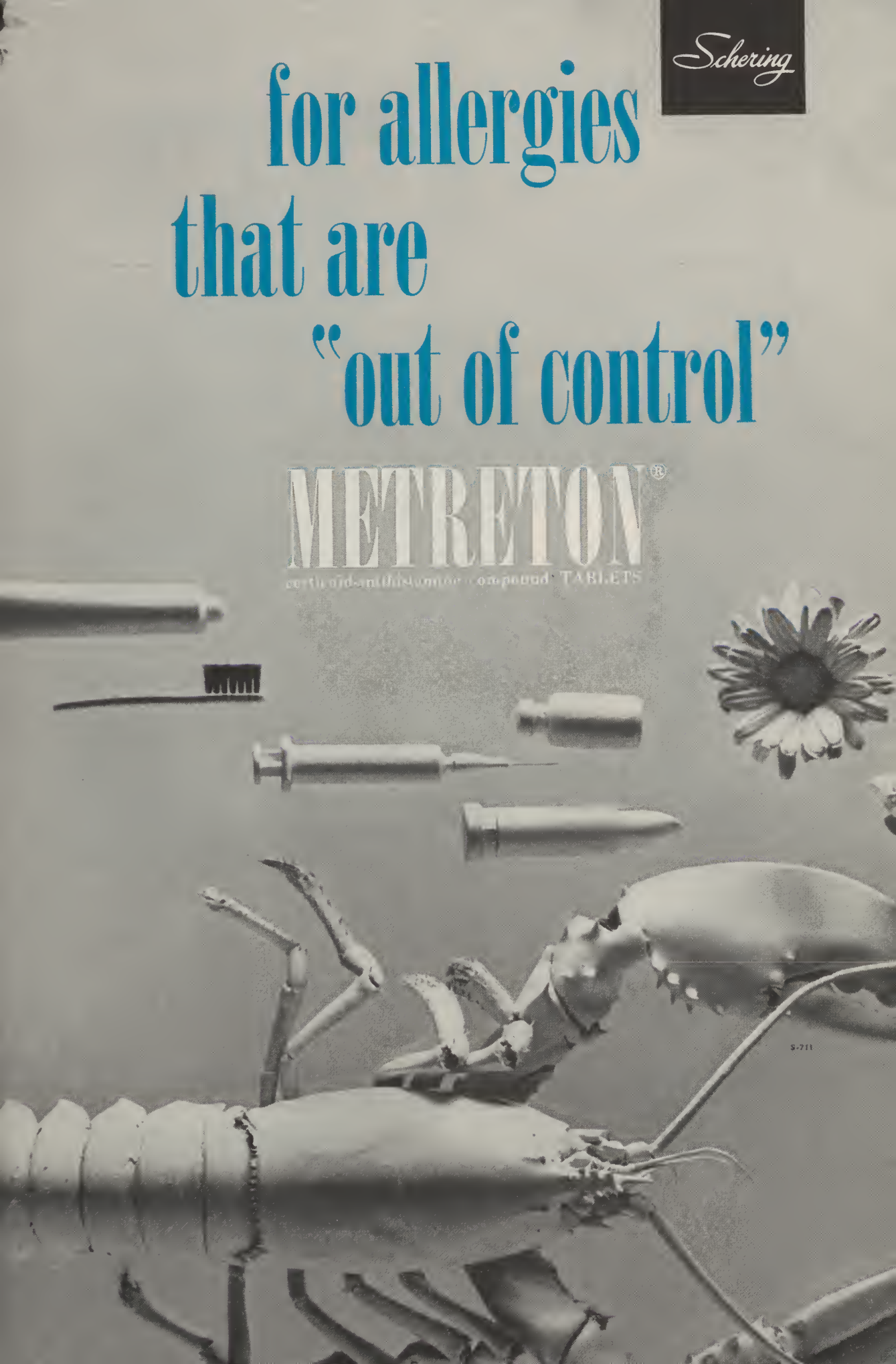
Blue Shield can do as good a job as we doctors will permit it to do—and it can do as good a job as we demand that it do. But in many areas of this land we physicians must lift the heavy hand of suspicion and restraint from our Blue Shield Plans and offer these Plans of ours a bold and helping hand of confidence and leadership. There may be other ways of saving free medicine, but Blue Shield lies close at hand—and ready. When do we begin to move?

Schering

for allergies that are "out of control"

METRETON®

corticoid-antihistamine compound TABLETS



S-711



Vertigo is reversible

Antivert® STOPS VERTIGO



moderate to complete relief of symptoms in 9 out of 10 patients[1]

Prescribe one ANTIVERT tablet (or 1-2 teaspoonfuls ANTIVERT syrup) 3 times daily, before each meal, for prompt relief of vertigo, Meniere's syndrome and allied disorders. Side effects are short-lived, usually only harmless flushing and tingling associated with vasodilation. ANTIVERT is contraindicated in severe hypotension and hemorrhage.

Supplied: Small blue-and-white scored tablets (meclizine HCl 12.5 mg. and nicotinic acid 50 mg.) in bottles of 100. Syrup in pint bottles. Prescription only. Bibliography available on request.

And for your aging patients—
NEOBON® Capsules: five-factor geriatric supplement.

Reference: 1. Scal, J. C.: Eye Ear Nose & Throat Month. 38:738 (Sept.) 1959.

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Science for the World's Well-Being®

now available:



Antivert syrup

Each teaspoonful (5 cc.) contains 6.25 mg. meclizine HCl and 25 mg. nicotinic acid.



He needs his muscles working properly—
when they aren't, he needs

Trancopal

How to use *Trancopal*®
Brand of chlormezanone
in musculoskeletal "splinting"

Although "splinting" of a joint by skeletal muscle spasm is often protective, it can go too far or continue too long. Then spasm, pain and disuse may lead to wasting.

When you prescribe Trancopal, you can prevent "oversplinting." Trancopal will relax the spasm, ease the pain and get the muscle working again. Relaxation generally begins within half an hour, and the effects of one tablet last from four to six hours.

In addition to relaxing the muscle, Trancopal will mildly tranquilize the patient, reducing the restlessness and irritability that so often accompany discomfort. With Trancopal, the patient can soon start purposeful exercise and physical therapy.

Trancopal has been found very effective in the treatment of patients with low back pain (lumbago), neck pain (torticollis), bursitis, fibrositis, myositis, ankle sprain, tennis elbow, osteoarthritis, rheumatoid arthritis, disc syndrome and postoperative muscle spasm. Trancopal is available in 200 mg. Caplets® (green colored, scored) and in 100 mg. Caplets (peach colored, scored), bottles of 100.

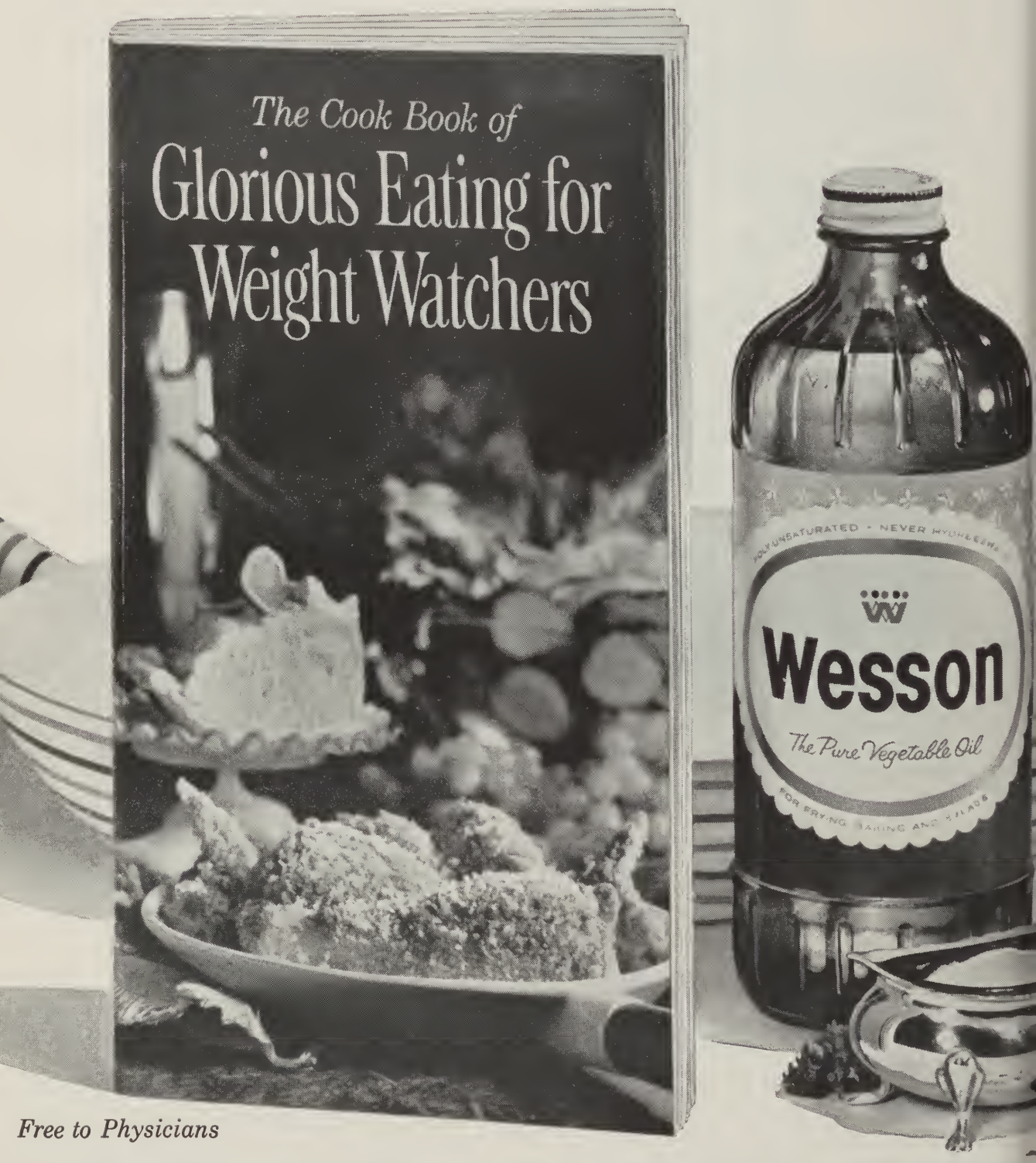
Dosage: Adults, 1 Caplet (200 mg.) three or four times daily; children (5 to 12 years), from 50 to 100 mg. three or four times daily.

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A REALISTIC AID TO PROPER WEIGHT MAINTENANCE

At Last...New Cook Book Designed



Free to Physicians

Menus fulfill the recommended dietary allowances of the Food & Nutrition Board of the National Research Council

Prevent Overweight Through Better Eating Habits

Recipes and Menus with Satiety and Appetite Appeal in Mind

The Cook Book of Glorious Eating for Weight Watchers fills the long-felt need for a weight control plan that is workable for everybody in the family. Realistic regimens are built around good, natural, readily-available foods enhanced by delicious methods of preparation. In place of "fad diets" or tasteless formulas, it provides for truly appetizing meals. It teaches and encourages the development of the healthful eating habits that can prevent overweight, America's #1 Health Problem. This full-color cook book contains 100 pages—248 delicious recipes each with calorie counts. Complete menus are here at 3 calorie levels—1200, 1800, 2600. Calorie levels are related to *best* weights by sex, age, size and extent of activity.

Many diets fail because they are crash programs only temporary in effect. Other diets are unbearable because they are monotonous and tasteless.

The Wesson way is not a crash program. It offers calorie controlled menus with appetite appeal, variety and satiety in mind. They fulfill the recommended dietary allowances of the Food & Nutrition Board of the National Research Council.

All menus provide the proper amount of protein, carbohydrates, fat and the other essential nutrients. The principles of good nutrition are included to help the homemaker plan her own properly balanced, calorie controlled menus. With simple subtractions or additions to the same basic menu, each family member can be served delicious satisfying menus according to his individual needs.

Not a reducing manual. It should be explained that "The Cook Book of Glorious Eating for Weight Watchers" is a guide to the *prevention of obesity.* Its publication marks the first time that a food manufacturer like Wesson has taken so important a step to help combat this serious public health problem.

Copies for physicians. "The Cook Book of Glorious Eating for Weight Watchers" is being offered to the general public. If you would like a copy for yourself, together with forms to enable patients to obtain their own copies, please fill in coupon below.



Note: *Please do not confuse this booklet with the Cholesterol Depressant Diet Book, published by Wesson as an aid to physicians and* for professional distribution only. *The concept of the Cholesterol Depressant Diet Book stems from Wesson's value in cholesterol depressant diets. Where a vegetable (salad) oil is medically recommended for a cholesterol depressant regimen, poly-unsaturated Wesson is unsurpassed by any readily available brand.*

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Please send me my copy of "The Cook Book of Glorious Eating for Weight Watchers", plus two dozen order blanks for distribution to my patients.

_____ M.D.

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Poly-unsaturated **Wesson,** *the Pure Vegetable Oil, is Never Hydrogenated*





in peritonitis

Therapeutic confidence

Panalba is effective against more than 30 commonly encountered pathogens including ubiquitous staphylococci. Right from the start, prescribing it gives you a high degree of assurance of obtaining the desired anti-infective action in this as in a wide variety of bacterial diseases.

Supplied: Capsules, each containing Panmycin* Phosphate (tetracycline phosphate complex), equivalent to 250 mg. tetracycline hydrochloride, and 125 mg. Albamycin,* as novobiocin sodium, in bottles of 16 and 100.

Adult dosage: 2 capsules four times a day.

Side effects: Panmycin Phosphate has a very low order of toxicity comparable to that of the other tetracyclines and is well tolerated clinically. Side reactions to therapeutic use in patients are infrequent and consist principally of mild nausea and abdominal cramps.

Albamycin also has a relatively low order of toxicity. In a certain few patients, a yellow pigment has been found in the plasma. This pigment, apparently a metabolic by-product of the drug, is not necessarily associated with abnormal liver function tests.

Urticaria and maculopapular dermatitis, a few cases of leukopenia, and agranulocytosis have been reported in patients treated with Albamycin. All of these side effects rapidly disappeared upon discontinuance of the drug.

Caution: Since the use of any antibiotic may result in overgrowth of nonsusceptible organisms, constant observation of the patient is essential. If new infections appear during therapy, appropriate measures should be taken.

As with any serious infection, therapy of peritonitis with Panalba or other antibacterial agents is adjunctive to surgical procedures and supportive therapy.

Inflammatory process of the peritoneum

The Upjohn Company
Kalamazoo, Michigan

Upjohn

75th year

*Trademark, Reg. U. S. Pat. Off.

Panalba*

your broad-spectrum antibiotic of *first* resort

WASHINGTON NEWS DIGEST

Washington, D. C.—The seriousness of the national problem of mental illness was emphasized on three fronts recently in the nation's capital.

First, the Joint Commission on Mental Illness and Health reported on a comprehensive five-year study of the over-all problem. Second, another special government advisory committee recommended smaller community-sized mental institutions after a two-year study of facilities for care of the mentally ill. Third, a Senate subcommittee held hearings on the constitutional rights of mental patients.

The Joint Commission recommended sweeping reforms in the treatment of mental illness as well as expanded and improved facilities. It said some gains had been made in the past 10 years but that the need for adequate facilities for humane, healing treatment of the mentally ill is still largely unmet.

More than half of the patients in state mental hospitals do not receive any treatment, largely because of inadequate facilities, the commission said.

The commission recommended that government spending at all levels—federal, state and local—for public mental patient services be stepped up in the next decade from the present $1 billion a year to $3 billion a year.

Another recommendation was that there be a fully-staffed, full-time mental health clinic for each 50,000 of population.

The commission, which was created in 1955 by a special act of Congress, had 45 members representing every national association and non-government agency concerned with mental health. The American Psychiatric Association and the American Medical Association had the leadership in setting up the commission.

The government advisory committee, composed of 12 state Hill-Burton and mental health authorities, recommended that states concentrate on smaller community or regional facilities "offering a wide spectrum of services."

Luther L. Terry, M.D., Surgeon General of the Public Health Service, urged state governors to use the advisory committee's recommendations as guidelines for improving mental health facilities.

The Senate Constitutional Rights Subcommittee heard from Winfred Overholser, M.D., that there is no foundation to charges that many Americans are "railroaded" into mental hospitals. Doctor Overholser is superintendent of St. Elizabeth's Hospital, large federal mental institution in Washington, D. C.

THE FOOD AND DRUG Administration, after the government filed suit against two drug firms for counterfeiting, reported that an extensive investigation showed that there is still relatively little counterfeiting of drugs.

Of 2,700 samples of drugs collected from 900 drugstores in the first three months of this year, only nine were found to be counterfeit.

FDA Commissioner George P. Larrick said he expected the problem of counterfeit drugs to continue because of the lure of easy profits. But he said results of the investigation supported the FDA view that "the facts to date do not warrant disturbing sick people about the quality of medications that they have been taking."

In the counterfeiting suit, General Pharmacal Company, Hoboken, N. J., and Lowell Packing Company, Long Island, N. Y., and eight officials of the two firms were charged with manufacturing counterfeit tranquilizers, diuretics, weight reducers and other drugs and selling them to drugstores in six states. The Justice Department charged that the companies put markings on pills making them appear like other trade-marked brands.

•

FDA ORDERED manufacturers, effective May 27, to supply samples of new drugs for testing by the government agency prior to clearance for sale.

In the past, the FDA has relied largely on scientific data supplied by the manufacturers themselves in clearing a new drug as being safe for sale. The FDA tested the drugs only on a limited and occasional basis and after they had been put on the market.

•

THE GOVERNMENT is spending $4.1 billion a year in the health field, a Senate Government Operations Subcommittee reported. In the most detailed report of its kind ever published by a governmental group, the Subcommittee, headed by Sen. Hubert H. Humphrey (D., Minn.), noted that $1.1 billion of the total cares for sick members of the armed forces and their dependents in hospitals. The tab for Civil Service workers' sick leave totals $315 million a year. About $650 million a year is spent on medical research, with most of this carried out by the National Institutes of Health and the Veterans Administration.

•

THE GOVERNMENT ordered 250 physicians drafted this year due to the failure of enough interns to sign up for military service. It is the first physician's draft in four years. All of the draftees will be assigned to the Air Force. A department spokesman said the draft call would not prevent individual physicians finishing internship this year from volunteering for Air Force medical duty.

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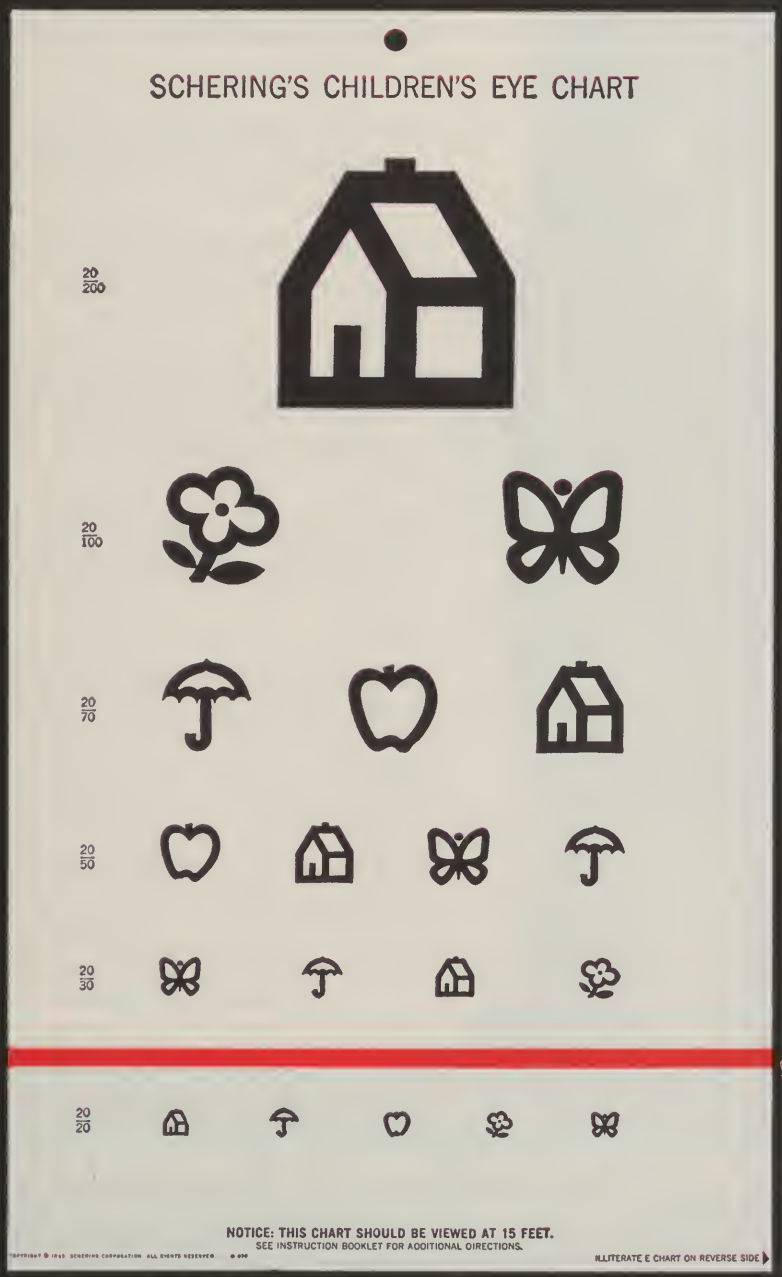
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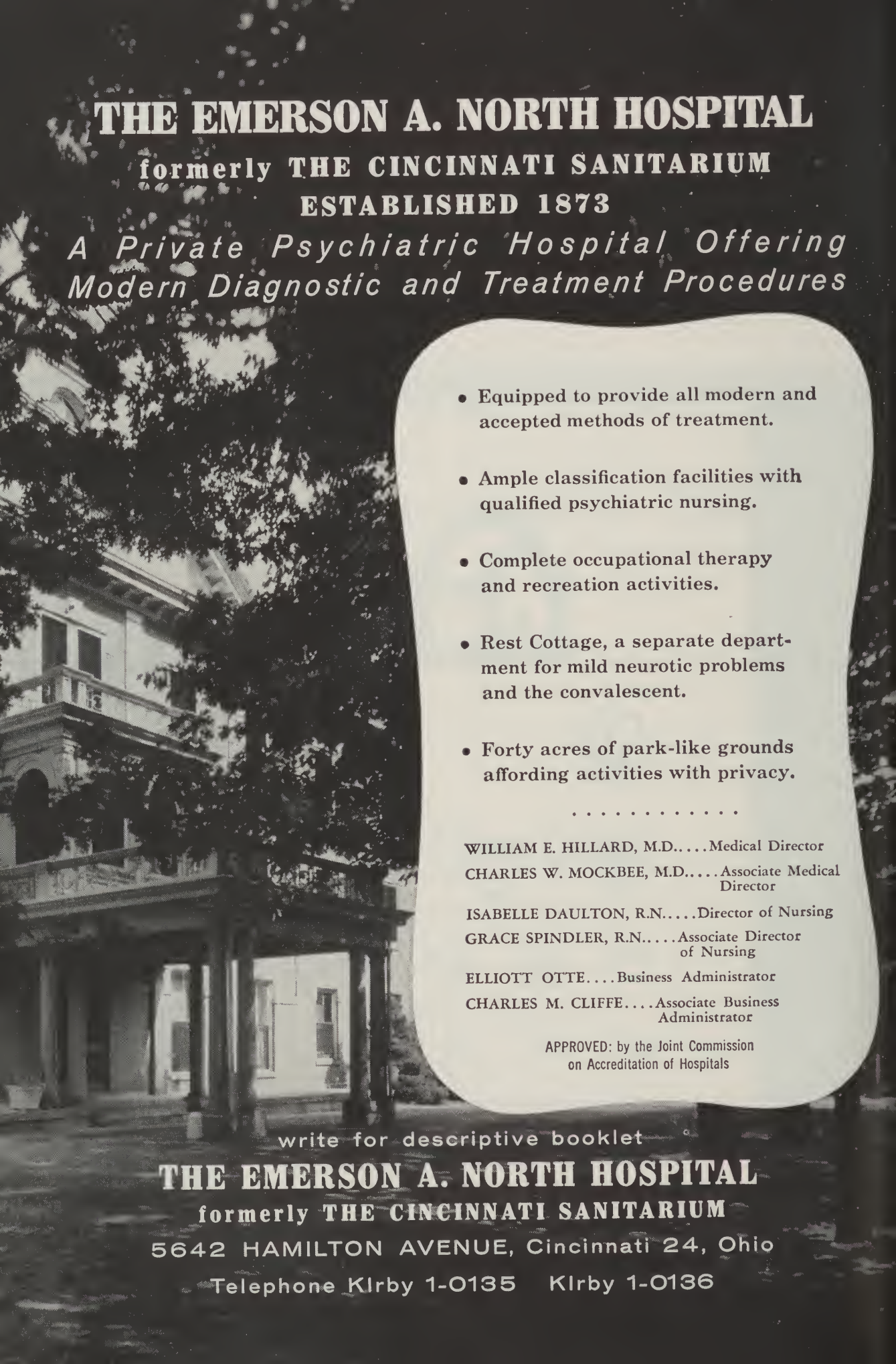
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Referred Pain In the Inflammatory Female Urethra*

M. RANDOLPH GILLIAM, M.D.

Lexington, Ky.

Chronic female urethritis is discussed with emphasis on the referred pain aspects of the problem. Statistics on 146 cases are presented and six illustrative cases are outlined.

THE terms urethritis and urethrotrigonitis are used interchangeably in this paper, since I consider them to be the same basic entity.

An analysis of the histories of women with urethritis indicates that the urologists have failed to impress the remainder of our profession with urethritis as an entity. This is especially true of the referred pain aspects of the urethritis syndrome. Otherwise we would not be encountering so many of these women who have been subjected to one or more surgical procedures, who have been labeled neurotics or who have been told that their symptoms were due to menopause without having had their urethrae examined.

Langdon Parsons says that the most common source of obscure pelvic pain is the urethra. He is a gynecologist speaking with reference to female pelvic pain. The same is true of the male. The medical profession generally lists the prostate among the first echelon of considerations when dealing with pelvic pain in the male, with or without urinary symptoms.

The medical profession does not, however, give similar consideration, generally speaking, to the urethra when confronted with a problem of pelvic pain in the female. This is simply a problem of inadequate education. One hears little or nothing concerning this problem in medical school. The interne or resident is seldom afforded contact with the problem of diagnosis and management of female urethritis, so that most physicians enter practice with essentially no knowledge of the existence of pain of female urethral origin.

Few of us question pain of prostatitis origin, yet relatively few of us know that similar pain problems exist purely because of inflammation in the female urethra. There should be no difficulty in correlating the two problems because the prostatic urethra in the male is homologus with the entire female urethra. Felix, in 1912, established this embryological fact. It is logical then that pain symptoms should be similar because the two structures are similarly innervated. One may wonder, however, because of the anatomical difference. This difference is merely one of degree because

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there are periurethral glands in the female urethra homologous with the prostatic glands, and both are subject to inflammation.

Anatomical Considerations

From the gross anatomical standpoint, the female urethra certainly seems to be an insignificant structure. It is only four centimeters in length, extending from the bladder to the vestibule. For a long time this structure was considered to be simply an epithelial-lined tube, even though Virchow wrote in 1853 that there are glands in the posterior female urethra homologous with prostatic glands in the male.

Folsom, in 1934, and Cabot and Shoemaker in 1936, began to stress the role of periurethral gland formation in the female harboring infection, but it was not until 1945 that significant extension of work along this line was published. Folsom, Lentegen, Herbert, Huffman and Benevenli, in separate works, have proved the presence of periurethral glands with duct formation and have attempted to stress the importance of these glands in the inflamed female urethra. Because of these findings the female urethra can no longer be considered as simply an epithelial-lined tube.

The position of the urethral orifice in the vestibule renders the female urethra vulnerable to bacterial invasion from vaginal and rectal sources from infancy through adult life. Its position renders it vulnerable also to trauma varying from mild to severe. The anterior relation of the symphysis pubis, which of course is rigid and fixed, makes for obvious trauma associated with intercourse and childbirth.

The presence of inflammatory changes can be recognized cystoscopically and has been proved histologically by many investigators. Cystoscopic findings may vary from hyperemia to severe polyp formation and hyperplasia of the urethral mucosa, usually more marked in the proximal portion. Periurethral fibrosis, with narrowing of the urethral lumen and associated stenosis, is a common finding and occasionally is quite marked. Folsom and others have reported cases of marked hyperplasia of the glandular elements of the proximal urethra associated with infection. In some cases where obstructive symptoms required transurethral resection, histologic appearances were not distinguishable from those of chronic prostatitis.

Symptomatology

In discussing the symptomatology, I do not wish to minimize the irritative bladder symptoms frequently associated with chronic urethritis, but the major purpose of this paper is to stimulate more concern about the less obvious, though not less frequent, symptoms. In some cases the symptoms of frequency and/or dysuria are absent or are so minimal as to be completely ignored by the patient.

Youngblood says that if a man complained of unilateral or bilateral referred pain to groin, suprapubic region, lower back, thighs and perineum, one would unhesitatingly look to the posterior urethra as a source of trouble and that the same should apply to woman. Hibbs lists four out of a series of 68 as having flank pain of urethral origin relieved by appropriate treatment. Folsom and Alexander have stated that pain within two feet of the urethra which cannot otherwise be adequately explained should bring to mind the urethra. Lucas includes referred pain to the suprapubic area, one or both lower quadrants, lower lumbar or sacral area, the vagina, the vulva, groin and inner aspect of the thighs.

A significant number of these patients have had one or more surgical procedures for such symptoms without relief, and many have been labeled "nervous" because no cause has been found to explain such symptomatology. Dyspareunia is not an uncommon complaint. Dyspareunia with resulting frigidity has been found by many writers to be associated with urethritis. It is only logical that a tender and inflamed urethra would produce pain during intercourse.

Diagnostic Points

The diagnosis of chronic urethritis in the female is simple enough. One must first of all be suspicious of the presence of this lesion on the basis of recognizable symptoms. It is important to remember that in the vast majority of cases a catheterized urine specimen is entirely negative. Therefore, absolutely no dependence can be placed on mere examination of a urine specimen whether voided or catheterized.

The diagnosis is made by endoscopy with findings as mentioned previously. If there is pyuria in a catheterized specimen associated

with urethritis, the upper urinary tract should be investigated to ascertain whether or not it is responsible. As a part of the diagnostic workup, vaginal tract infection should be looked for and treated if found. Hibbs found that 40 per cent of his cases had definite cervicitis.

The relationship of vaginal tract infection to chronic urethritis is two-fold. First, there is unobstructed direct extension of infection by way of the vestibule into the urethra and then there is lymphatic spread from the cervix to the periurethral and subtrigonal areas.

Treatment

Treatment must be individualized to fit the specific needs of each case, but there are some items which seem to me to be basic. A cardinal point is the eradication of local and distant sources of infection which feed the urethra. Unless this is accomplished, other treatment is likely to prove inadequate in relieving the symptoms more than temporarily, if at all. The genital tract is the most frequent source by far and should, therefore, be thoroughly evaluated for inflammatory lesions. I will not attempt to go into the types of lesions and their treatment because of the limited scope of this paper.

Treatment of the urethra itself is of prime importance and there is considerable unanimity of opinion among writers on this subject. Oral medication is not mentioned by any writer in discussing the treatment of this condition. Dilatation of the urethra is the common denominator mentioned by all writers in describing treatment of chronic urethritis. The caliber of dilatation varies to some extent from one writer to another, from size 28F to 32F. The interval recommended varies slightly, from five to seven days.

Most writers dilate the urethra following instillation of silver protein or silver salts solutions into the urethra. Urethral suppositories (Furacin and Furestrol) after urethral dilatations are also mentioned in some of the later papers. Lucas says that after about six to eight treatments, 90 to 95 per cent will obtain relief.

My own approach to treatment is to give weekly dilatations until the patient has obtained complete relief for the entire intervening week. This amounts to four to six treatments in the great majority, but sometimes two will be sufficient. From that point I increase the interval progressively until I am satisfied that the patient can be put on a probationary status. As a general rule this means a three months asymptomatic interval. In cases with severe and longstanding symptoms I maintain an interval of three to four months until a period of relief has been sustained for a year before considering probation.

It is my opinion that the caliber of dilatation should be suited to the individual urethra. In my experience, most require 30F dilatation and a few require up to 45F. This is because of the obvious variations in the normal female urethral caliber, just as one finds such variations in the male. Failure to dilate these larger urethras to their normal caliber is responsible for a sizeable per cent of so-called therapeutic failures. Urethral meatotomy should be done if diminished caliber of the meatus limits the caliber to less than the caliber to which urethra should be dilated.

Transurethral desiccation of the proximal urethral and trigonal mucosa should be done if the response to more conservative treatment is unsatisfactory. A failure to resort to this procedure will be responsible for some inadequate therapeutic responses. There should be no poor results in dealing with chronic urethritis if the patient is followed adequately and attention is paid to details, with individualization of the problem.

Treatment in most instances is relatively simple but these patients are among the most grateful.

Review of 1957 Experience

Total number of women patients in 1957—226
Total number having chronic urethritis—146 or 65.5%
Presenting complaints due to urethra—120

Age—Youngest 19 years
Oldest 78 years
Average 39 years

Duration of Symptoms

Shortest	1 week
Longest	20 years
Average	2½ years

Without significant irritative bladder symptoms—29 (19.7%)
Had associated vaginitis or cervicitis—48 (32.9%)
Not evaluated as to response—48
Number evaluated—98

Response to treatment

Excellent	— 53 (54%)
Good	— 37 (37.8%)
Fair	— 8 (8.15%)

Required transurethral fulguration—5

The problem is a common one in my experience, as evidenced by a review of my 1957 female practice. There were 226 new women patients in 1957, 146 (or 65.5%) of whom had symptoms which were established as due to chronic urethritis. One hundred and twenty were seen initially for complaints that were subsequently proved to be from urethritis. Twenty-six were seen for some other urological problem, but a survey of symptomatology led to the diagnosis of urethritis.

The following presentation of six cases graphically illustrates some features of this problem:

Mrs. J. W. M. 38 years
#30031



Duration of Symptoms
18 years

Location and Type of Pain
Suprapubic, both groins, both lower abdominal quadrants, severe two years. Dyspareunia persistent 18 years.

Irritative Bladder Symptoms
Intermittent for 3 years. Episode of right pyelonephritis 3 years before.

Previous Treatment Relative to Pain
Uterine suspension and left oophorectomy in 1944 without relief. Many doctors and much oral medication with no significant relief.

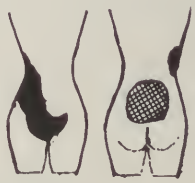
Cystoscopic Findings
Marked polyp formation in proximal urethra and bladder neck. Moderate trigonitis. Bladder other than trigone normal. Normal pyelograms.

Treatment
MSP and urethral dilatations first to 30F and later 36F.

Response
Dramatic partial relief initially. Complete relief by sixth treatment which sustained.

Followup
35 mos. 16 mos. relief without treatment and then return. 2 treatments to relief.

Mrs. M. W. 35 years
#31348



Duration of Symptoms
Severe 2 weeks. Mild and intermittent three to four years.

Location and Type of Pain
Right flank, right lower quadrant, bilateral inguinal and sacral. Severe enough to interfere with work for two weeks.

Irritative Bladder Symptoms
2+ frequency for two weeks.

Previous Treatment
None.

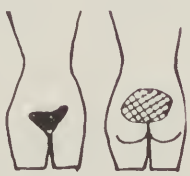
Cystoscopic Findings:
Urethra tight to 18F. Marked edema of mucosa, mild trigonitis. Pyelograms normal. A'so Trichomonas vaginitis.

Treatment
Anti-trichomonas prescription. MSP and dilatations to 30F by fourth treatment. Eventually to 32F.

Response
Only slight improvement until third treatment. Almost complete relief by fifth.

Followup
24 mos. Now doing well on 2 to 3 month's interval.

Mrs. E. T. 28 years
#29633



Duration of Symptoms
Nine to ten years,

intermittent. Five years persistent.

Location and Type of Pain

Suprapubic, inguinal, moderately severe. Sacral, mild to moderate.

Irritative Bladder Symptoms
2+ Frequency and urgency

Previous Treatment Relative to Pain
Cysts removed from both ovaries 4 years previously. No relief.

Cystoscopic Findings
Cicatricial urethritis. Tight to 24F

Treatment
MSP* and urethral dilatations to 34F eventually.

Response
Moderate relief after first, complete after eighth. Dismissed on probation.

Followup
27 mos. Asymptomatic.
* Mild Silver Protein

Mrs. L. K. 35 years
#30829



Duration of Symptoms
Six months

Location and Type of Pain

Sacral, RLQ, both thighs, Incapacitating for 2-3 weeks. Dyspareunia.

Irritative Bladder Symptoms
Frequency 2+. Slight intermittent dysuria.

Previous Treatment Relative To Pain
None. Medicines without relief.

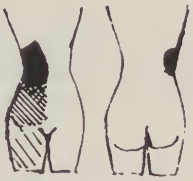
Cystoscopic Findings
Urethra snug to 24F. Hyperemia and thickening of mucosa 2+. Bladder normal.

Treatment
MSP and dilatations eventually to 34F.

Response
Completely relieved by second treatment and this continued until interval was increased to four weeks after fifth treatment. Relieved again after two weekly treatments. Relief sustained.

Followup
27 mos. 18 mos. period of relief without treatment and on return 3 treatments asymptomatic and so now for 5 mos.

Miss S. I. 46 years
#31073



Duration of Symptoms
Six months

Location and Type of Pain

Right flank, right upper quadrant, right iliac and right lower quadrant. Burning and aching aggravated by straining somewhat and at times severe. Right thigh at times.

Irritative Bladder Symptoms
Mild day frequency and nocturia 2 times.

Previous Treatment Relative to Pain
Cholecystectomy, hysterectomy and appendectomy, no relief. Postoperative cholangeogram negative.

Cystoscopic Findings
Mild cicatricial involvement. Congestion and thickening of mucosa and early polyps.
Bladder normal. Pyelograms normal.

Treatment
MSP and urethral dilatations initially to 30F and later to 36F.

Response
Aggravation of symptoms by first treatment. Three days relief by second. Complete relief by fourth.

Followup
24 mos. Asymptomatic on four treatments. Now on probation.

Mrs. G. F. 56 years
#28035



Duration of Symptoms
3 years

Location and Type of Pain

Suprapubic retropubic and perineal severe. Mild sacral. Severe dyspareunia.

Irritative Bladder Symptoms
1+ Mild frequency. Moderate dysuria at times.

Previous treatment relative to pain
Supracervical hysterectomy—3 years.
A&P repair 2 years.
Several doctors and much medicine and no relief. Treated with estrogens for menopause syndrome without relief.

Cystoscopic Findings
Cicatricial urethritis. Tight to 24F.

Treatment
MSP and urethral dilatations eventually to 32F.

Response
Dramatic relief after 1st treatment. Five treatments to complete relief.

Followup
40 mo.—Last asymptomatic interval 2 yrs. Before that 5 mos.

Summary and Conclusions

1. Referred pain in the female urethritis syndrome has been discussed and several representative cases outlined.

2. This problem is much more frequent than is generally recognized by the medical profession.

3. Treatment is simple and in the great majority of cases affords relief.

4. Attention to the eradication of local and distant sources of infection and adequate followup with attention to individual variations will increase the number of relieved patients.

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Hypersensitivity In Children*

Harry S. Andrews, M.D.
Louisville, Ky.

Continuous colds of children are usually due to allergy which is divided into two groups—recurrent upper respiratory disease and perennial allergic rhinitis

THE words "hypersensitive," "sensitive" and "hypersusceptible" are used synonymously in the literature. They are also used to express the same meaning as "allergic." A hypersensitive patient responds to substances that would not provoke visible response in normal individuals; or may respond to smaller amount or respond in a much more exaggerated manner. Therefore, hypersensitivity may be defined as an altered or an increased reaction to antigen or hapten with harmful effects on the body.

Von Piquet coined the word "allergy" with the meaning of "changed or altered reactivity" and intended the word to embrace immunity as well as hypersensitivity.

Classification

Allergy then should include anaphylaxis, serum sickness, Arthus reaction, delayed sensitivity and immunohematological diseases. All of these are examples of "altered reactivity" on immunological grounds. It may include non-immunological reactions such as the Schwartzman phenomenon, anaphylactoid shock and atopic symptoms (due to physical agents) or urticaria, asthma and rhinitis.

Hypersensitive reactions are divided into: (1) immediate or (2) delayed (early and late). The difference is greater than the time element, as shown in the following comparison:

Hypersensitivity
Early
(1) Produced by ordinary antigen introduced in ordinary way or by inhalation of foreign material such as pollen.
(2) Circulating anti-bodies.
(3) Passive transfer from serum.
(4) Found only in vascularized tissue; changes in blood vessels, smooth muscle and collagen.
(5) No hypersensitivity of tissue cells in tissue cultures.
Late
(1) Requires infectious agents or prolonged contact with skin or adjuvants (Waxy).
(2) No circulating antibodies.
(3) No passive transfer via serum but can be by special cells.
(4) Reaction can be elicited in non vascular tissues.
(5) Cellular sensitivity demonstrated in tissue cultures.

The main types of hypersensitivities are: (1) Arthus phenomenon (and possibly periarteritis nodosa); (2) urticaria, anaphylaxis and atopy (in man); (3) certain blood dyscrasias; (4) allergy of infection; (5) contact allergy; (6) serum disease.

I will limit this discussion to those hypersensitivity problems found most often in children. These fall under the heading of atopy (clinical forms of hypersensitivity which are affected by an hereditary predisposition). The more com-

*Presented at a joint meeting of the Kentucky State Medical Association's 12th and 15th Trustee Districts at Cumberland Falls, Kentucky, on May 5, 1960.

mon clinical forms found in children are: (1) "hay" fever or allergic rhinitis; (2) perennial allergic rhinitis; (3) asthma; (4) urticaria (hives); (5) atopic dermatitis; (6) angioneurotic edema; (7) migraine (8) gastro-intestinal allergy; (9) recurrent otitis media; (10) chronic sinusitis; and (11) recurrent upper respiratory disease.

Of these, I will consider only recurrent upper respiratory disease and perennial allergic rhinitis, two of the most common clinical forms of hypersensitivity found in children.

Diagnosis

In ferreting out these problems and working out the solution, one must first get a *detailed* history of the nature of the illness—when it was first discovered, whether it has progressed, whether it is seasonal and in which season it is most prevalent, and whether there is a hereditary background. In fact, a detailed history from an undisturbed mother is the most important step in the process.

After the history is obtained, a good physical examination, including all necessary laboratory procedures, should be done, paying especial attention to the organs described in the history.

This should be followed by special tests needed to confirm or repudiate the impression gained from the history. These are: (1) scratch; (2) intradermal, and (3) passive transfer skin tests and ophthalmic tests.

From this accumulated data one can fairly well determine the cause and recommend remedial measures. It is important at the end of the complete examination to explain to the parents, in their own language, the difficulty and what is necessary to correct it.

RURD

Recurrent upper respiratory disease of allergic origin will be referred to as RURD. Perennial allergic rhinitis will be referred to as PAR. These are very common conditions in children. RURD has been found to rank fourth in allergic diseases. MacKinney and Glaser[1] found RURD in 31% of allergic children studied under 10 years of age. Asthma won first place with 53%. It is important not only as a great nuisance at this age but because it is a precursor of bronchial asthma. RURD may be classified as (1) allergic; (2) infectious, or (3) allergic and infectious.



The Allergic Salute



Infected tonsils and adenoids are often confused with this syndrome. It may be safely said that any child who needs a T and A before 3 years of age will be an allergic child. This is also true of people who have had to have a T and A more than once, and also of those people who have had chronic sinus disease and occasionally is associated with polyps of the nose or sinuses. The same may be said of recurrent serous otitis media.

Cohen and Rudolph[2] have carefully studied the difference between infectious and allergic conditions of the upper respiratory tract. In fact, if their table is used carefully a diagnosis may be made by history alone.

Combined Allergic and Infectious

Primary allergic conditions are often secondarily infected. Cure depends on recognition and relief of the allergy. The body then overcomes the infection in most cases. This does not preclude treatment for the infection when indicated.

RURD occurs in children who have more than three colds per winter with or without

chest involvement. Their mothers are usually frantic about the child being ill all winter. Many are referred from nose and throat people who say that they haunt their offices. The mothers say they cannot tell when they have colds or not.

PAR

Perennial allergic rhinitis or PAR is somewhat different from RURD and is also sadly overlooked. Here the child has a "cold all the time" and "can't blow his nose." He breathes through his mouth. It occurs all year, becoming worse with the "house dust season" which begins when the house is shut up and the furnace turned on in September until the furnace is stopped in the spring. It may be worse during the pollen season.

The symptoms are similar to pollenosis but not as acute and with less eye symptoms. The patient blows his nose often but without results. He may have a "hawking" from a post nasal drip. The child may have a chronic intractable cough, worse at night, with a persistent laryngitis. When he's lying on the side the "down side" stops up while the "upper side" is open, resulting in tossing from side to side with restless sleep.

They may have a peculiar mannerism of "nose to mouth wrinkling" or the allergy salute as described by Bowen[3] in 1928.

RURD is a frequent precursor of bronchial asthma. This is less true with PAR. Both have basically the same pathology as asthma except the mucus membrane of the nasopharynx is involved instead of the bronchial tree.

The complications of RURD are the same as of URI. PAR in children commonly produces sinus disease and less frequently polyps. Deafness may become present if allowed to continue over long periods. It may interfere with development of sinuses and produce dental abnormalities giving the "allergic facies."

Treatment

Treatment of RURD is exactly the same as asthma and responds readily to management. However, PAR in children is next to chronic urticaria in adults in the difficulty of obtaining good relief. House dust sensitivity is usually present in both but is more commonly found in PAR. In infants and young children foods may play a very important part in the etiology. Bacterial vaccine may be useful. Removal of diseased tonsils and adenoids may help and polyps must be removed, if of any size or if of long duration. (Do not do nose and throat surgery during pollen seasons.)

Differential Diagnosis Of Allergic And Infectious Condition of Upper Respiratory Tract

History

Allergic	Infectious
1. Attacks usually recurrent.	1. Attacks usually single.
2. Often mild symptoms between attacks.	2. Usually clears up completely.
3. Definite relation to heredity.	3. No relation to heredity.
4. Not contagious.	4. Contagious.
5. Not related to exposure to another case.	5. Definite relation to exposure to another case.
6. Constitutional symptoms slight.	6. Constitutional symptoms more marked.
7. Foods and inhaled substances often traced as causes.	7. No relation to foods or inhalant substances as cause.
8. Itching common.	8. No itching.
9. Wheezing common.	9. No wheezing.
10. Other allergic conditions present or in past history.	10. Usually no other allergic condition present or in past history.

Examination

Allergic	Infectious
1. Visible mucous membranes pale, glistening, edematous.	1. Visible mucous membranes hyperemic, red.
2. Thin watery mucoid nasal discharge, mucoid sputum.	2. Mucopurulent or purulent nasal discharge and sputum.
3. Smear shows 10 per cent or more eosinophils.	3. Smear shows polymorphonuclear neutrophils as predominant cell; eosinophils few or absent.
4. Other signs of allergy often present.	4. No other signs of allergy.
5. Sinus involvement of hyperplastic type.	5. Sinus involvement of purulent type.
6. Wheezing breath sounds.	6. No wheezing breath sounds.
7. Roentgenogram shows bronchial markings increased.	7. Bronchial markings not increased in roentgenogram.
8. Allergic skin reactions usually positive.	8. Allergic skin reactions usually negative.

Summary

Continuous colds of children are usually due to allergy. They are divided into two groups. One group, the RURD, has symptoms which are intermittent and acute, resembling the common cold. The symptoms of the second group are less acute but more continuous, coming from chronic allergic congestion, and should be called PAR. (Not pollenosis, which is seasonal.)

The diagnosis is made by (1) history, (2) appearance of mucus membrance, and (3) appearance, in many instances, of eosinophils in mucus (but absence does not rule it out). Both should be studied by the hypersensitivity technique. Both can be treated fairly well symptomatically by environmental control, antihistamines, nose drops and cough preparations. If infection is superimposed, then antibiotics should be used judiciously.

Specific therapy helps RURD well, but PAR responds with difficulty. It is important to diagnose and treat these two conditions not only to relieve the immediate distressing symptoms but to prevent the development of bronchial asthma which may follow both, especially the RURD.

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3. Picture provided through the courtesy of Dr. Jerome Glaser. It appears in his book "Allergy in Childhood," Charles C. Thomas, Springfield, Ill. Through courtesy Dr. Ralph Bowen.

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The Surgical Treatment Of Thyroid Disease*

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The antithyroid drugs and radioactive iodine are effective in treating certain types of thyroid disease. However, surgery remains the treatment of choice for most cases.

WHAT role does surgery play in the modern treatment of thyroid disease? Some of our medical colleagues would imply that the very title of my address is an anachronism; that except in rare instances, surgery is no longer necessary for the treatment of any patient with thyroid disease. Not only do I believe that this is not so, but the main point that I should like to make is that surgical intervention must still be seriously considered in the treatment of every aspect of thyroid pathology as we see it in clinical practice.

With a few exceptions these cases may be divided roughly into four main groups: acute or chronic thyroiditis; nodular goiter; carcinoma of the thyroid, and primary hyperthyroidism or exophthalmic goiter.

Thyroiditis

A. Acute

Acute thyroiditis is uncommon. Very rarely, it may go on to suppuration and require incision and drainage. The disease is self-limited, responds to x-ray therapy, to the antibiotics, to thiouracil and to steroid therapy.

B. Chronic

One might ask why surgery would be indicated in a patient with chronic thyroiditis who may already show evidences of thyroid deficiency. There are three reasons. One is to establish a definite diagnosis, the second is to relieve an annoying sense of constriction in the neck and the third is to eliminate the disfigurement of a goiter.

In a few patients with the common variety of thyroiditis, Hashimoto's struma, the diagnosis is so definite that they may safely be watched. In these patients the consistency of the gland is the same throughout, and the typical symmetry of the gland is preserved, except for the increase in size. Unfortunately, in many patients, even with Hashimoto's struma, the enlargement will not be symmetrical and will be so suggestive of carcinoma that malignancy cannot be excluded except by histological examination. This is found even more so in patients with Riedel's struma. It is also true in many cases of nonspecific chronic thyroiditis which is often seen in association with other types of thyroid pathology.

The typical clinical picture of Hashimoto's struma is a patient with discomfort in the neck and a goiter, frequently associated with a low basal metabolic rate. The treatment for most of these patients will be a conservative type of subtotal thyroidectomy. This will provide tissue for a definite diagnosis; it will relieve the constricting pressure about the trachea, and it will correct a protruding goiter.

Adenomatous Goiter

Most patients with an adenomatous goiter require surgery for one or more of three reasons. The first is the size of the goiter itself. Not only does a large protuberant goiter in the neck become distressing to the patient from a cosmetic point of view but it also produces compression and deviation of the trachea.

Goiters grow so slowly that a patient may

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have considerable narrowing of the trachea without being aware of it, even though the inspiratory stridor can be heard while the patient is speaking. As a goiter increases in size it also descends in the neck. If it enters the superior thoracic strait, all of its future growth is downward and is concealed within the thorax.

The patient may give a history of having had a goiter for many years which has recently become smaller in size. Actually, the goiter has continued to grow, but now the large part of the mass is where he can neither see it nor feel it and only that which remains above the sternum has become smaller.

An intrathoracic goiter should always be removed because it always produces compression and deviation of the trachea. It is important that, before surgery, the surgeon be aware of any intrathoracic extension. Intratracheal anesthesia is a safeguard for any patient having a thyroidectomy, but it is essential for the patient with an intrathoracic goiter. If a semirigid tube is not in the trachea at the time a large intrathoracic goiter is delivered from the chest, complete occlusion of the airway may occur. This may lead to serious brain damage or even a fatality within a few minutes. In cases of nodular goiter, if the physician cannot feel the lower border of the gland, roentgenograms should be taken of the patient's trachea to determine whether or not he has an intrathoracic extension of his goiter.

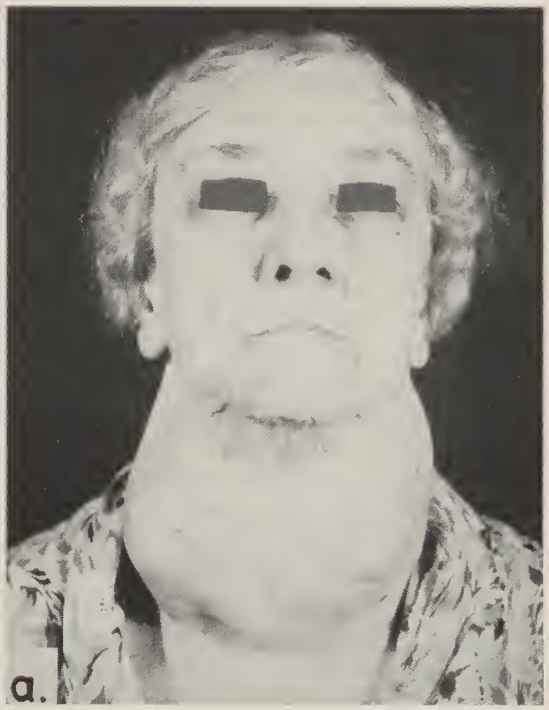




Figure 1. a and b—Hyperthyroidism due to a large nodular goiter. Hyperthyroidism may develop from a nodular goiter which the patient does not know she has.

Secondary Hyperthyroidism

The second reason that surgical intervention may be necessary in a patient with nodular goiter is the association of secondary hyperthyroidism (Figure 1). If these patients live long enough, they run a very real risk of having toxic symptoms develop as a result of the goiter. They are usually over 50 years of age, and the increased metabolism may lead to cardiac decompensation in a patient who already has cardiac impairment. Indeed, the symptoms of decompensation may obscure the signs and symptoms of thyroid toxicity. Yet it is important that the hyperthyroidism not be overlooked since relief of the hyperthyroidism usually results in rapid recovery from the cardiac decompensation. Many of these patients will have no further cardiac symptoms once they are relieved of the increased metabolic stimulus from their goiter.

Because these patients are not young and may have cardiac damage, they should be care-

fully prepared with the antithyroid drugs. Several months may be required to bring a patient with toxic, nodular goiter to a euthyroid state where operation can safely be carried out. It is possible, however, to relieve these patients of their goiter and their toxicity with a very reasonable operative risk. They tolerate even mild degrees of anoxemia poorly following surgery. For this reason, in recent years we have done a prophylactic tracheotomy in all thyrocardiac patients undergoing operation. This has lowered the mortality of thyroid surgery even in this group of patients to a fraction of 1 per cent.

The third reason that surgery must be considered for a patient with nodular goiter is the possible presence of carcinoma. We believe that the patient who has a single, solitary nodule is more likely to have carcinoma of the thyroid than a patient with a multiple nodular goiter, but the presence of more than one nodule does not exclude cancer. For this reason, unless the goiter is small and contains many nodules, none of which are firm or changing in size, it should be removed.

Carcinoma of the Thyroid

In recent years the incidence, significance and treatment of cancer of the thyroid has been the subject of a great deal of controversy. Undoubtedly its incidence varies in different parts of the country. This is particularly true when it is related to the incidence of nodular goiter.

Much of the wide variation in frequency as reported in the literature is related to selection of patients. A clinic known for its interest in thyroid disease will see a larger percentage of patients with cancer of the thyroid than will a physician in general practice. Nevertheless, patients who consult their family physician because of a lump in the neck represent a group in which the percentage of cancer in nodular goiter is higher than it would be in the general population. This is particularly true in a goiter area. The very fact that the nodule is large enough for it to come to the patient's attention (and frequently increasing in size) puts him in a selected group. In our experience, cancer of the thyroid represents 5 to 6 per cent of all thyroid cases and 8 to 10 per cent of patients with a nodular goiter (Table 1).

The majority of patients with cancer of the thyroid are under 50 years of age and it is twice as common in females as in males. Unfortunately, cancer of the thyroid produces no symptoms during its early stages. Dyspnea, voice changes and discomfort are all symptoms of advanced malignant disease. The *only* sign or symptom of a cancer of the thyroid *at a stage when it is curable* is a lump in the neck in or near the thyroid gland.

In our experience papillary carcinoma, the most favorable type of thyroid malignancy, comprises only 39.3 per cent of thyroid carcinoma. The majority, 55.2 per cent, is either follicular or follicular mixed with papillary elements. This type of malignancy has a more serious prognosis.

Table 1

Carcinoma of Thyroid—1957

Incidence (not including 10 patients referred with diagnosis of carcinoma)

	Per Cent
All thyroid patients	6.2
All nodular goiter	7.9
Nontoxic nodular goiter	8.8
Solitary nodular goiter	33.8

(Above diagnoses—as confirmed by histological examination)

The treatment of thyroid cancer is based on the histological type of malignancy present plus its clinical extent. Complete removal of the thyroid lobe containing the tumor, plus the isthmus and adjacent portion of the opposite lobe, is first carried out. If the frozen section diagnosis is papillary adenocarcinoma or mixed papillary and follicular adenocarcinoma, a radical neck dissection is immediately performed on the side of the tumor. In our experience, 50 per cent of these patients already show cervical lymph node metastasis. The sternomastoid muscle and the internal jugular vein are removed along with the contents of the anterior and posterior triangles; the spinal accessory nerve is usually preserved. Thyroid cancer rarely involves the upper part of the posterior triangle or the submental area. It is important that a clean dissection of the upper mediastinum also be carried out.

It has recently been reported that cancer of the thyroid is frequently multicentric in origin. This has not been our experience and, although we have not done a total thyroidectomy for

papillary adenocarcinoma, recurrence in the remaining opposite lobe is extremely rare. For patients with follicular adenocarcinoma it is important to remove all of the primary tumor and surrounding gland. Since these tumors invade blood vessels and may produce distant metastases one does not have the same excellent opportunity to remove all of the cancer and its primary spread by a radical neck dissection, as in papillary adenocarcinoma.

With patients who have carcinoma simplex, either of the giant or small cell variety, one is not justified in doing a neck dissection since these tumors show little tendency to metastasize to the lateral nodes of the neck. A total thyroidectomy with removal of as much tumor as possible is done and these patients are given supervoltage radiation. The prognosis is poor but some of these patients have been cured by aggressive surgery and radiation.

Much of the confusion surrounding this subject is due to the variable behavior of the different forms of thyroid cancer. Certain facts, however, may be kept in mind. A patient with a firm nodule in his thyroid gland has a 10 per cent chance of having cancer. If he is advised to leave it alone until it "bothers him" he loses his best chance for a cure. It can be removed with practically no mortality and he will spend less than five days in the hospital. If it proves to be malignant, it can still be completely removed by an operative procedure which carries little or no mortality and which is not mutilating or disabling. If cancer of the thyroid is not completely removed or destroyed, even the most favorable variety will eventually lead to a fatality.

Primary Hyperthyroidism

Primary hyperthyroidism (exophthalmic goiter, Graves' disease) must be distinguished from the hyperthyroidism which is associated with an adenomatous or nodular goiter. They differ in their response to iodine, to the antithyroid drugs and to radioactive iodine. Myxedema may follow treatment of primary hyperthyroidism with the antithyroid drugs, radioactive iodine or thyroidectomy. It is very rare in patients with nodular goiter and hyperthyroidism regardless of treatment.

The diagnosis of exophthalmic goiter in a typical case is not difficult. The patient with borderline hyperthyroidism may require careful study and prolonged observation to establish the diagnosis. The diagnosis may also escape detection in patients with apathetic hyperthyroidism. In such cases the disease has been present for so long that they no longer appear activated. They may have no exophthalmos or other obvious signs of thyroid toxicity. A loss of weight, lack of strength, elevated pulse rate and a small, but firm gland may be the only signs of thyroid disease present.

We are fortunate today in having three effective ways of treating primary hyperthyroidism—the antithyroid drugs, radioactive iodine, and the combination of antithyroid drugs plus subtotal thyroidectomy (Table 2).

Table 2

Hyperthyroidism—Choice of Treatment

A. Thyroidectomy after antithyroid preparation
   1. First choice for all good risk patients
   2. All nodular goiters
B. Prolonged antithyroid treatment
   1. Mild Graves' disease with small goiters
   2. Recurrent Graves' disease—mild, small remnants
C. Radioactive iodine
   1. Recurrent Graves' disease
   2. Graves' disease over 50—poor surgical risk

1. The antithyroid drugs, if given in sufficient dosage over a sufficient period of time, will relieve all of the symptoms in a patient with hyperthyroidism. Unfortunately, however, in over 50 per cent of these patients the disease will recur if the drug is stopped. This means that as a definitive treatment of hyperthyroidism the antithyroid drugs alone run a very poor second to either radioactive iodine or surgery. They may be used for the occasional patient with a small to moderate size goiter who refuses surgery or for whom surgery is contraindicated. They should not be used for patients with nodular goiter and secondary hyperthyroidism and they are inferior to radioactive iodine for patients with recurrent primary hyperthyroidism.

2. Radioactive iodine, if given in sufficient amount, will completely destroy the thyroid gland and thus relieve the patient of all symptoms of thyroid toxicity. It has some very definite disadvantages, however, which, in our

opinion, keep it from being the procedure of choice for most patients with exophthalmic goiter. The dose must be determined by the estimated size of the gland. As all thyroid surgeons know, this is subject to considerable error. As a result, the incidence of myxedema associated with radioactive iodine therapy is high (up to 25 per cent). It also means that re-treatment is frequently necessary and this may bring the cost close to that of surgery. Moreover, there is likely to be a poor response to later doses. The greatest danger, however, is that the patient may be left with persistent hyperthyroidism.

As yet there is no direct evidence that radioactive iodine can cause cancer of the thyroid. We know that the incidence of cancer of the thyroid has increased in young adults who received radiation to the neck 15 to 20 years previously, so it is too soon to state definitely that radioactive iodine is or is not carcinogenic. The possibility that radioactive iodine may produce mutation changes in the ovaries of young women has also not been definitely settled.

TABLE 3

I^{131} Therapy in Primary Hyperthyroidism

Indications

1. Recurrent primary hyperthyroidism
2. Primary hyperthyroidism over age of 45-50
3. Primary hyperthyroidism and severe organic or mental disease
4. Primary hyperthyroidism in professional singers

Our indications (Table 3) for radioactive iodine therapy in patients with hyperthyroidism are: (1) recurrent primary hyperthyroidism; (2) primary hyperthyroidism in patients over 45 to 50 years of age; (3) primary hyperthyroidism in patients with severe organic or mental disease and (4) occasionally, in patients such as professional singers. It is not used for any patient with nodular goiter and secondary hyperthyroidism. It is not only less effective in these patients, but there is always the danger that carcinoma of the thyroid may be present.

3. Thyroidectomy after antithyroid preparation, we believe, is the treatment of choice for the majority of patients with primary hyperthyroidism. These patients are prepared with propylthiouracil, which has a low incidence of undesirable side reactions. It is given in a dosage of 300 to 400 mg. daily but can be given in a much higher dosage (1000 to 2000 mg. daily) if a rapid response is urgent. Its effect is predictable and one can plan in advance for such things as hospital reservation.

In patients with primary hyperthyroidism, propylthiouracil will produce an average fall of one point per day in the basal metabolic rate. Thus a patient with an initial metabolism of + 60 will be ready for surgery in approximately two months. Iodine is used in addition to propylthiouracil during the last ten days of treatment to produce involution of the gland. This permits thyroidectomy to be carried out with a relatively small loss of blood. We feel that it is essential that patients come to surgery in the euthyroid state but not with myxedema.

The most important aspect of the thyroidectomy is adequate exposure. The recurrent laryngeal nerve and the parathyroids can be exposed and preserved. A radical subtotal thyroidectomy can be done with very little risk.

Subtotal thyroidectomy is associated with a low mortality rate and a low morbidity rate. Our mortality rate at the present time is less than 0.2 per cent. The incidence of postoperative myxedema is less than 5.0 per cent; tetany, less than 2.0 per cent, and unilateral recurrent nerve injury, less than 0.1 per cent (a bilateral injury should never occur). These patients spend less than one week in the hospital and all of them are relieved of their hyperthyroidism. Even the rate of late recurrence (10 to 15 year follow-up periods) is less than 2.0 per cent.

Prolapse And The Puerperium

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A specific hormone of fibrous involution is postulated. Measures resulting in the total remission of uterine prolapse which existed before pregnancy are discussed

As young families increase in size, the cumulative damage to the mothers' pelvic supporting structures becomes greater. An inevitable sequel is a higher incidence of symptomatic prolapse in the young gravida.

It is appropriate, therefore, to review our thinking about the puerperium. A method of managing it is presented here, together with illustrative cases and certain impressions and conclusions drawn from them.

The Hypothesis

The axiom that the most constant factor in nature is its diversity is abundantly fulfilled in the case of the fibrous supporting tissues of the female pelvis. The elasticity, density and friability of these tissues are as variable as people themselves. This factor of variability so dominates the picture of puerperal involution that quantitative conclusions require large control series to be valid. The observations and conclusions given here are not supported by such statistically valid series. They are based on qualitative changes in cases followed in private practice, and are presented as impressions or hypotheses rather than dogmatic statements.

It is generally agreed that lactation improves involution. The contraction of the uterus in response to suckling is an obvious factor. The average obstetrician can sort his patients into nursing and non-nursing groups by pelvic examination alone, six weeks post partum, with a fair degree of accuracy. The logical inference is that if a mother does not nurse her baby, she should maintain lactation by pumping her breasts.

In following patients who have adopted this routine, I am satisfied that there is a specific factor at work shortening and thickening the fibrous supports of the pelvic viscera. If this is so, the less tension placed on these supports by a heavy sub-involuting uterus in the early post partum weeks the better. This tension is the one great disadvantage of early ambulation. Prolonged bed rest is one method of relaxing it. A better one is the early use of pessaries designed, insofar as possible, to transfer the load of the involuting uterus from the fibrous tissues of the upper pelvic diaphragm to the muscular ones of the pelvic floor. Weak muscular supports are strengthened by use, weak fibrous ones are damaged by it.

The Treatment

These concepts are explained to patients, and a high percentage of them elect to cooperate. At the onset of lactation, the breasts are pumped ad libitum to relieve congestion. Before the end of the first week, most mothers have settled down to a routine of pumping three or four times a day.

During this first week, the patients are fitted with a simple folding c i r c u l a r pessary and t a u g h t to place and remove it themselves. There have been no complaints relating to the episiotomy or any infections so far. Median episiotomies are used. The patients are sent home wearing the pessary and taking the next two smaller sizes in order to maintain support as the vagina contracts. At the six week post partum visit, they return the pessaries and do not use them again.

Examples

The following cases, presented in chronological outline form, are illustrative of the benefits I attribute to the treatment discussed above.

Mrs. J. S., age 33

1951—Male, 6 lbs. 12½ ozs. R.S.A. position with a right median episiotomy. Dried breasts.

1953—Was complaining of intermittent backache at period time and following exertion.

1955—Had developed constant aching pain in both lower quadrants, a sense of perineal bulging, severe backache, and pain radiating into her thighs, particularly with menses. Pelvic examination revealed relaxation of the perineum and vaginal walls, with descensus and hypermobility of the uterus.

1957—Female, 7 lbs. 4 ozs. L.O.A. position, spontaneous, with median episiotomy. This pregnancy was marked by severe mechanical pressure symptoms. She nursed this baby for three months and, except for going to the bathroom, stayed on complete bed rest for 30 days post partum. Before this pregnancy she could not complete the family ironing without lying down. Since she resumed full activity, she has had no symptoms of prolapse. She notes that her cervix has retracted higher within the vagina.

Mrs. M. .H, age 35

1941—Male, 8 lbs. ¾ ozs. Uneventful pregnancy, labor and delivery. Nursed three weeks.

1955—Female, 7 lbs. Uneventful pregnancy, labor and delivery. Dried her breasts during first post partum week.

1959—She complained of backache, dyspareunia and aching pain in the lower abdomen radiating into the thighs.

1960—Male, 7 lbs. 13 ozs. Pregnancy marked by hydramnios and mechanical pressure symptoms. Delivery uneventful. She pumped her breasts and wore a pessary post partum. She denies any symptoms of prolapse and reports that she can do a day's work without pain. There is objective cervical retraction.

Mrs. B. M., age 29

1951—Female, 7 lbs. 5 ozs. Uneventful pregnancy, labor and delivery.

1954—Male, 9 lbs. 14 ozs.—one month after expected date of confinement. This patient is 5′ 8″ tall, with an average non-pregnant weight of 165 pounds. She has been under treatment by an orthopedic surgeon intermittently since 1953 for intrinsic low back disease. Since her delivery in 1954 she had increasingly severe typical symptoms of pelvic prolapse which she differentiates from her chronic low back pain; namely lower abdominal pain, a sense of pelvic dragging, perineal fullness and pain radiating to the legs, exacerbated by long standing and housework, and relieved by getting off her feet.

1960—Male, 9 lbs. 7 ozs.—4 days after E.D.L. She nursed her baby, wore pessaries of graduated smaller sizes and, despite objective relaxation of her pelvic tissues, reports absence of symptoms of prolapse, stating that she feels "better than after any baby yet," and can complete her daily work without pain referable to her pelvis.

Mrs. G. N., age 21

1955—Male, 5 lbs. 15 ozs.—delivered two weeks before expected date, four hours labor. Nursed 10½ months post partum. Pregnancy marked by backache starting at 7 months. At 6 weeks post partum complained of backache and bilateral inguinal pains on long exertion.

1957—Female, 5 lbs. 1 oz.—delivered one month before expected date, spontaneous delivery, uneventful pregnancy. Nursed one month post partum. Complained of pain in low back on bending, rising, and lifting, and

bilateral inguinal pain. Pelvic examination showed moderate relaxation and descensus.

1959—Seen in office. Complained of bilateral lower quadrant pain, worse at end of day. Relieved by lying down.

1960—(3/23/60) Female, 6 lbs. 2½ ozs., —on time, spontaneous delivery— uneventful pregnancy. Post partum course marked by nursing and use of pessaries of decreasing size, self placed. This patient had symptoms of descensus following first and second children. She could not complete a family ironing without lying down. After third child, she irons for five hours before developing pain. There is objective retraction of cervix within the vagina. Her words are that "she feels firmer inside."

Addendum

Since the above report, 44 multiparas have been followed through the puerperium. All either nursed or pumped.

Total Cases	44
Incomplete or contradictory reports	5
Corrected Cases	39
Complete remission of preexisting symptoms	15
Improved	19
Unchanged	4
Worse	1
	39

Graduated pessaries started in the first week were used only in patients with severe symptoms of pre-existing prolapse. No complications attributable to pessaries have developed and they will be used more freely in the future.

Used Pessaries	21
Benefited	20
No Benefit	1
Lactation Only	18
Benefited	14
No Benefit	3
Worse	1
Total	39

This series is too small for statistical significance, but it is felt that the ratios reported warrant investigation on a larger scale.

Discussion

The definite remission of disabling symptoms of prolapse existing prior to pregnancy in these cases is not meant to imply an equally favorable result in every instance. The factor of individual variation mentioned above rules that out. The over-all impression, however, is of better intra-pelvic involution and fewer and milder symptoms of prolapse. These benefits are most apparent in mothers of two to four children.

The prophylactic measures described could reasonably be expected to arrest the symptoms of prolapse in status quo. For them to decrease or disappear is another matter. This indicates the action of some specific and unknown agent producing a clearly identifiable effect. It is possible that this agent is a pituitary hormone, comparable to but not identical with prolactin, produced under the stimulus of lactation. It may be an unrecognized action of a known substance.

In any event, it is reasonable to suspect the existence of a hormone having a firming and shortening effect on these tissues; particularly since the discovery of relaxin, which has such a precisely timed and definite action in the other direction. The disappearance of relaxin within 48 hours of delivery permits the presumption that it is making way for an antagonistic substance whose function is the repair of the herniation of the birth canal caused by childbirth. If such a substance proves to be a specific entity, its logical name would be the antonym of relaxin, i.e., contractin; and the possibility of a medical attack on the problem of pelvic prolapse would exist.

Summary

1. Nursing or breast pumping and relaxation of the upper pelvic diaphragm by bed rest or preferably the early use of pessaries in the puerperium promotes the shortening and thickening of the fibrous pelvic supports.

2. These measures, in some instances, have resulted in the total remission of disabling symptoms of pelvic prolapse which existed before pregnancy.

3. This remission has persisted as long as three years post partum.

4. A specific hormonal mechanism of fibrous involution which appears or is increased in response to lactation is postulated.

Treatment Of Metrorrhagia In Adolescence

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Louisville, Ky.

Metrorrhagia in adolescence is not uncommon. Most cases may be observed if of minor degree. Progesterone therapy to produce cyclic withdrawal bleeding is advised when necessary

FUNCTIONAL uterine bleeding or dysfunctional bleeding (and while some have distinguished between these two terms, I have used them synonomously) occurs throughout menstrual life, but more frequently in adolescence and near the menopause. In most instances, adolescent metrorrhagia is self-limiting and no therapy may be necessary. Reassurance and observation often are followed by the development of normal menstrual cycles.

Undoubtedly this condition has been known for an indefinite period of time, and must have been a factor in chlorosis, described so frequently in the 18th and 19th Centuries. In those days the association of metrorrhagia with anemia was well known, but many thought that anemia caused the bleeding. Today we believe the anemia is largely secondary to the bleeding, although considerably affected by the patient's dietary intake of iron.

Curettage of the uterus for metrorrhagia was first offered by Récamier in the early part of the 19th Century, and this procedure commonly has been used until the past few years in the treatment of young women with abnormal and prolonged bleeding. Hysterectomy was a recognized treatment for severe bleeding in young women during the first half of this century; intracavity radium and external roentgen therapy have been used with the intention of producing temporary amenorrhea, but often it proved permanent. Novak and Hurd[8] highly recommended chorionic gonadotrophin in 1931, and later (1942) I felt that administration of equine gonadotrophin produced good results.[3] Since then, these hormones have been largely discarded and cyclic administration of estrogen and progesterone has become the treatment of choice.[1,5,7,9]

The average age for the menarche in this country is approximately 13 years. In the first few months or even two years, the ovary of the young girl ordinarily does not ovulate, and produces a non-secretory endometrium from the estrogenic hormone; cyclic withdrawal bleeding occurs when the ovaries cease to produce estrogen. Such menstruation may or may not occur regularly, and prolongation and irregularity are common.

When the estrogenic hormone from the ovaries is excessive or continues over prolonged periods without complete withdrawal, the endometrium may remain in the non-secretory state and be associated with irregular bleeding, or it may become greatly thickened with the formation of cystic glandular hyperplasia and may be associated with prolonged and profuse bleeding. Intermittent amenorrhea is not uncommon. As a rule, these young women eventually develop normal cycles with ovulation and the formation of a corpus luteum. In a small percentage of cases the abnormal bleeding may continue into the late teens or later menstrual life.

In order to determine that the form of bleeding is functional and caused by hormonal abnormalities, one must eliminate the possibility of systemic disease and gestation, and search for local disease. Systemic diseases include par-

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ticularly the blood dyscrasias, as thrombocytopenic purpura, aplastic anemia or the rare leukemia. Walsh[10] reported two fatal cases occuring at 18 years from thrombocytopenic purpura. Several authors have advised that every patient who has abnormal uterine bleeding have a thrombocyte count.

This author has known of one such case cured by splenectomy, but this disease is quite uncommon in adolescent metrorrhagia. In 200 consecutive adolescents with gynecologic complaints we found pregnancy in six.[4] Pregnancy must be ruled out or considered in accordance with the history and examination. Such local disease as polyps, benign tumors, or carcinoma of the cervix, endometrium, or ovary are quite rare. Thirty-four of 200 adolescent patients with gynecologic complaints had metrorhagia, one of which had a granulosal cell carcinoma of the ovary.[4]

Examination

Examination of the young woman includes a general physical examination with particular reference to the physique, abnormal weight, degrees of anemia and thyroid status. Thrombocyte counts are to be considered. Pelvic examination includes a one-digit vaginal examination if the hymen is suficiently enlarged, but never is this approach insisted upon. Often one must rely on the rectal examination to palpate the size, shape and position of the uterus and to determine the presence or absence of pelvic tumors.

Endometrial biopsy or curettage of the uterus is rarely necessary for the study of the very young patient. Basal temperature graphs may be of interest but are largely unnecessary. Nervousness undoubtedly is a factor in certain instances of functional uterine bleeding, especially when it occurs in mid-menstrual life. The psychogenic aspect is not to be overlooked.

Treatment

The treatment of adolescent bleeding in the past has consisted of curettage of the uterus when the bleeding has seemed sufficiently severe, and this has been helpful in controlling the bleeding at least temporarily. However, in recent years, as hormone therapy is better understood, curettage is unnecessary as a rule. Hysterectomy is practically always unnecessary in the adolescent. X-ray and radium treatments for metrorrhagia in the young are strictly undesirable therapies at this time.

Thyroid extract may be of great value in certain instances in which the patient has the clinical findings to indicate this therapy. These include fatigue, slow pulse, lowered blood pressure, dry skin, fine hair and perhaps overweight, associated with the proper laboratory findings. Weight control is of importance in normal ovarian function. The obese must be reduced to normal and the asthenic must be urged to gain weight. Therapy for psychosomatic disorders may be of importance on occasion, though less important in the adolescent than in later life. The therapy of anemia is to be considered in the individual case.

Estrogenic hormone for the control of metrorrhagia has been particularly advanced by Karnaky, who has demonstrated methods for the use of estrogens more than any other author. Karnaky[6] has suggested that micronized stilbestrol be given in increasing amounts for eight weeks to three months, beginning at 6.25 mgm. daily, and increasing to 100 mgm. daily. He has controlled bleeding as an emergency treatment by prescribing 25 to 50 mgm. of stilbestrol every fifteen minutes until bleeding ceases, then 50 mgm. daily for six weeks. In addition, he has advised the administration of vitamin B complex.

Progesterone of Great Value

We have used stilbestrol 5 mgm. daily for 20 days, then desisted for eight days, and have repeated the therapy in this cyclic manner with apparent control of bleeding. Similarly, we have used conjugated equine estrogens, 5 mgm. daily for 20 days in each 28 days for several months with control. However, the use of estrogens has seemed to us not as satisfactory as that of progesterone, as there is a more complete denudation of endometrium during the withdrawal bleeding than after estrogenic therapy. This may be of only theoretical importance.

Progesterone, after the introduction of its use by J. S. L. Brown in 1938, followed by a more definitive paper by Albright in the same year, has proved of great value to us in the treatment of functional uterine bleeding of all ages. In 1949 we reported the use of proges-

terone in 76 patients with functional uterine bleeding, eight of whom had adolescent bleeding.[2] Of the latter, four were apparently cured after several cycles of progesterone withdrawal bleeding, one had recurrence after six months, and one developed temporary amenorrhea. Two of these continued to have intermittent prolonged and profuse bleeding, being controlled only as long as progesterone was given.

In one instance we continued the progesterone at intervals from the age of 18 until the age of 25 years, in courses of four months each, after which the patient was allowed to menstruate spontaneously. Abnormal bleeding soon returned and further progesterone was necessary. At the age of 25 the patient became pregnant, delivered a normal child, and in the next few years had normal menstruation. Progesterone in this case was used as 10 mgm. in oil intramuscularly daily for five days, followed three days later by withdrawal bleeding. Similar withdrawal bleeding followed progesterone in doses of 12.5 mgm. or 25 mgm. in oil daily for 5 days, after 50 mgm. in beeswax peanut oil in single injections, and after a single dose of 125 mgm. in oil.

Report of Cases

In addition to the eight cases with adolescent bleeding reported by us in 1949, we have treated 48 young private patients as shown in Table I. The ages were fairly evenly distributed between 12 and 17 years of age. Thirty-nine had metrorrhagia (prolonged and profuse irregular bleeding), three had oligomenorrhea and metrorrhagia, and six had menorrhagia. Organic disease was present in four, including incomplete abortion, subacute salpingitis, Stein Leventhal syndrome, and granulosal cell carcinoma.

The treatment used in these 48 adolescent girls included progesterone in 24, given as 50 mgm. in oil intramuscularly on alternate days for two doses, repeated at 28-day intervals for four months. In all but one case the results were satisfactory. In the one a granulosal cell carcinoma was removed one year later. In another, temporary difficulties seemed related to ovulation and the patient's own corpus luteum which would interfere with withdrawal bleeding. Testosterone propionate, 50 to 100 mgm. in oil, was used in five cases on occasion for immediate control. We prefer little of this virilizing hormone.

Thyroid extract was administered to 16 patients, apparently with improvement. Mild sedation was used in five. Curettage was performed in only four patients, one of whom had an incomplete abortion. Reduction of weight was accomplished in two. In three cases, since the bleeding was not excessive, observation was followed by normal menstruation.

TABLE I
Adolescent Metrorrhagia—48 Cases

ages-years	10	11	12	13	14	15	16	17
cases	1	2	7	8	8	9	3	10

Metrorrhagia	39	Salpingitis	1
Oligo-metro	3	Stein-Levinthal	1
Menorrhagia	6	Abortion	1
		Granulosal cell tumor	1
Treatment.			
Progesterone	24	Curettage	4
Testosterone	5	Reduce weight	2
Thyroid	16	Observation	3
Sedation	5		

One patient had salpingectomy at 17 years for severe inflammation not responding to conservative therapy. Both ovaries had wedge resection in one case with Stein-Leventhal syndrome (more often associated with oligomenorrhea) with improvement for several years. But later in adult life, curettage on two occasions has been necessary.

When necessary (in half of our cases in recent years), four series of progesterone withdrawal bleeding are used to control the metrorrhagia for four months. Then menstruation may revert to normal. If metrorrhagia recurs, four series are repeated. Eventually normal menstruation has developed.

Progesterone does not stimulate the ovary, but controls bleeding until the patient's ovaries begin to ovulate, form a corpus luteum and produce normal cyclic withdrawal bleeding of menstruation. The 19-nor-testosterone derivatives (norethynodrel [Enovid®] and norethindrone [Norlutin®] may be used to produce amenorrhea for a long period of time with increased dosage, or they may be used to produce withdrawal bleeding three days after the cessation of therapy. The long-acting progestin (17-alphahydroxin progesterone caproate, [Delalutin®] administered in 125 mgm. dosage is followed two weeks later by withdrawal bleeding.

Other newer and potent oral progestins (as Provera, Upjohn) may be used in 2.5 to 10 mgm. dosage daily for 5 days and may be followed by similar predictable withdrawal bleeding.

Summary and Conclusions

Functional uterine bleeding in adolescents is not uncommon and may be expected to be more frequent because of the normal anovulatory cycles which occur in the first few years of menstrual life. Often the adolescent ovaries produce a sustained, irregular, or excessive amount of estrogenic hormone. The vast majority of these patients will develop normal menstruation and the main therapy is directed toward the control of blood loss and the treatment of anemia, temporizing until the natural sequency of ovulation, corpus luteum formation, and normal menstruation occurs. Thyroid extract, mild sedation, reduction of weight, and curettage (on rare occasions) may be helpful in establishing normal cycles. Testosterone propionate may be administered as stat doses for temporary improvement.

Of 48 adolescents with metrorrhagia treated by us in recent years, progesterone was administered in 50 mgm. doses to 24, intramuscularly on alternate days for two days, repeated at 28 and 30 day intervals for four months. Menstruation subsequently was regulated and apparent cure achieved in all but one. In this instance, the patient proved subsequently to have a granulosal cell carcinoma of the ovary, apparently cured after local excision of the one ovary.

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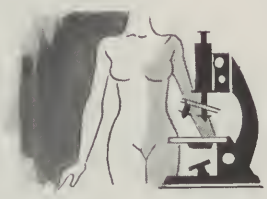
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Precautions: Collateral hormonal effects generally associated with corticosteroids may be induced. These include Cushingoid manifestations and muscle weakness. However, sodium and potassium retention, edema, weight gain, psychic aberration and hypertension are exceedingly rare. In the treatment of allergic respiratory disorders, dosage should be individualized and kept at the lowest level needed to control symptoms. Dosage should not exceed 36 mg. daily without potassium supplementation. Drug should not be withdrawn abruptly. Contraindicated in herpes simplex and chicken pox.

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CASE DISCUSSIONS
From The
University of Louisville Hospitals

Louisville General Hospital

A Concerted Approach to the Problem of Osteoarthritis Secondary to Obesity

Case presented by Xuan T. Truong, M.D., Resident in Physical Medicine and Rehabilitation

A 49-year-old white female was admitted to the Rehabilitation Service on 4-12-60 with a history of increasing pains in both knees for five years and inability to walk for two years prior to admission. She had become increasingly obese since the age of 20, reaching a maximum of 326 pounds on admission, with a height of 5 feet, 5 inches. Her previous hospital record revealed several admissions for "psychoneurosis," "neurasthenia" and "conversion hysteria."

Before admission to the Rehabilitation Service, she had been treated as an outpatient with various reducing diets, various arthro-analgesics and physical therapy to the lower extremities, but without much success as to obesity and physical invalidism.

Examination on admission showed marked obesity, severe tenderness around both knees but without any significant swelling or redness, sub-luxation of the right knee, extension contractures in both knees with no flexibility on the left and ability to flex only from 180 to 160° on the right, contractures of both heel cords, and severe pains in the knees on the slightest weight-bearing and on the least motion of the lower extremities.

Laboratory values of interest were an Erythrocyte Sedimentation rate of 20mm/1 hr. and a Latex fixation of (elasify) 1/80. X-rays of the right knee revealed narrowed joint space, demineralization of the osseous structures and medial sub-luxation of the femur; films of the left knee showed marked hypertrophic changes with exostosis of the femoral condyles and tibial plateau.

The patient was immediately started on a drastic reducing diet of 500 calories per day with the adjunctive use of phenylaminopropane alginate (Levonor) to alleviate any excessive feeling of hunger. On this regimen, she lost 100 pounds during the five months of her hospitalization, or an average of 4.5 pounds per week. Periodic short courses of Diuril (chlorothiazide) were used to reduce the body water accumulation associated with any rapid weight loss. There were no manifestations of dietary deficiencies as checked by frequent physical examinations, hemograms, serum protein determinations and liver function tests.

Simultaneously, the patient was carried through an intensive program of physical restoration, including medical and physical sedative measures for the joint pains, joint mobilizing exercises and muscular strengthening exercises progressing from isometric to isotonic exercises as the ranges of motion improved. Gradual weight-bearing on the lower extremities was obtained through the use of the tilt-table.

At the time of discharge, range of motion in the knees had improved to 180-105° on the left and 180-90° on the right, and the patient was ambulating well with minimal discomfort with one cane and without any bracing. She was completely independent in her self-care

activities. She has lost another 40 pounds since discharge while supervising her own reducing regimen, and is now helping to care for her elderly mother.

Discussion

Luis Spamer, M.D., Assistant Professor, Department of Physical Medicine and Rehabilitation

This presentation illustrates the necessity of a properly timed and multidirectional therapeutic approach in an adequate environment for the rehabilitation, or "third phase of medicine," of progressive invalidism. This 49-year-old white female reached a state of tremendous dependency, probably gratified psychologically, due to triggering of a vicious cycle of obesity-osteoarthritis-obesity, rendering her wheelchair-bound and bedridden.

The past history indicates a great amount of emotional vulnerability and maladjustment in her life, with various evidences of psychosomatic symptoms. The most overt sign of them was probably her admission to this hospital on April 3, 1959, with the diagnosis of "conversion hysteria, monoplegia."

Although causative factors of obesity are still poorly understood, most experts in this field involve the central nervous system and metabolic functions, and do not ignore psychogenic factors. Medical examination in this specific case did not reveal any major disturbance, and it was felt we could safely assume a predominant psychogenic factor. Inactivity imposed by the locomotor system invalidism, moreover, favored the accumulation of fat. It has been experimentally shown that reduction of activity below a certain level does not diminish appetite accordingly.[1]

Physical restoration of function in the "contracted knees" demanded a fair amount of emotional adjustment to tolerate the painful stretching and to furnish the required effort for concentrated muscular strengthening exercises.

In order to achieve any results, the therapeutic approach had to be directed toward: (1) improvement of emotional adjustment, (2) correction of caloric intake and output, and (3) relief of contractures. Supportive psychotherapy, by supplying her with attention and warm interest, succeeded in creating positive attempts by the patient to regain better adjustment in her own life situation. We were aware that the deeper type of therapy may have increased her self-assistance, but this was not accessible to us.

A drastic reduction in caloric intake to as little as 500 calories daily was tolerated without any significant detrimental effects,[2,3] and the in-patient environment provided her with the necessary regulation of caloric intake and output, along with the improvement of her physical achievements and self-dependency in activities of daily living.

It was always felt that the amount of knee disability shown did not correspond to the organic picture, as evidenced by physical examination and X-rays, and that a psychogenic overlay was definitely present. One of the differential characteristics of osteoarthritis and rheumatoid arthritis is the slight degree, if any at all, of joint ankylosis in the former as opposed to the marked tendency for this in the latter.[4] In the course of her therapy, this was corroborated by a sudden dramatic improvement of her knee contractures, which at the end of her restoration program enabled her to ambulate with a cane after two long years of complete and progressive invalidism.

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SPECIAL ARTICLES

A Landmark In Medicine

WILLIAM R. WILLARD, M.D.*

IN today's ceremonies we are commemorating one of a series of landmarks in the development of the University of Kentucky's Medical Center. Perhaps the first landmark in its modern history is a combination of several events. There was the commitment by Governor Chandler and the university to proceed with the development of this Center and the approval by the General Assembly of the Governor's budget, providing the initial sum of necessary money. From this followed the appointment of staff and architects and the various planning activities.

The second landmark was the ground-breaking ceremony celebrated in December, 1957. The third is this dedication, commemorating the beginning of our educational programs and the completion of the Medical Science Building.

There will be other landmarks to come, such as the dedications of the College of Dentistry and the University Hospital.

This service is similar to a commencement exercise. Although it reflects the completion of a major phase of development, the construction of a building, its real importance is to mark the beginning of programs of teaching, research and service. The importance of this occasion is the beginning of an era, rather than the conclusion of one.

We may ask a more specific question—the beginning of what kind of era? Its character can be forecast from the objectives of this Medical Center. These were derived from the 1953 reports of the University Faculty Committee and the Legislative Research Commission on Medical Education, and are as follows:

1. To educate more physicians and other kinds of health personnel to serve Kentucky and the nation.
2. To provide more educational opportunities in the health fields for the youth of Kentucky.
3. To provide postgraduate or continuing education so that health workers can keep abreast of the rapid developments in medical care.
4. To facilitate research in the medical sciences.
5. To provide medical care for some of the indigent.
6. To develop a base from which the Medical Center can serve all of the people of this Commonwealth.
7. To further upgrade the quality of medical care available to the people of Kentucky.

The most urgent need was stated to be the training of more physicians and the most pressing problem that of the distribution of physicians and health personnel in favor of the rural and small town areas. Meantime, there has emerged clearly the critical national need to educate more physicians and medical scientists.

Our charge, therefore, as derived from these reports and considerations, is a broad and for-

*Vice-president of the University of Kentucky Medical Center and dean of the U. of K. College of Medicine. *Address delivered at the Medical Center dedication in Lexington, Kentucky, on Friday, September 23, 1960.*

ward looking one. It includes the responsibility for medical statesmanship, for leadership in helping the Commonwealth and our nation to meet their important health problems. This may be stated in another way: The Medical Center is being created to meet some basic needs of the people of Kentucky and of the nation. It is not an end in itself, but a means to an end. It is an instrument to serve our people.

To help our people meet their important health problems, a Medical Center is required, not just a medical school. Therefore, we are dedicating a Medical Center, one that contains a College of Medicine, a College of Nursing, a College of Dentistry and a University Hospital. It also includes a fine Medical Center Library and the University Health Service. We are dedicating a Center that will develop in time additional programs for the education of other kinds of health personnel, and one that will develop other kinds of patient care facilities for teaching, research and service.

The Medical Center staff and the university have taken and are taking seriously their responsibilities. We have planned our buildings, we are recruiting our staff, and we are shaping our programs in ways that will meet these objectives and accomplish our mission.

Aims and Responsibilities

As you can judge, our ambition is to develop a Medical Center of quality, one that will command national distinction.

We cannot discharge these responsibilities alone, however. No Medical Center can meet all the health needs of its area. We can be a source of trained personnel, a center of learning, of special skills and resources which cannot be duplicated easily in the state, if at all, elsewhere; we can be a resource for physicians and health workers, for hospitals and health agencies, both governmental and private. Through these various persons and agencies, most people in Kentucky will continue to receive their health services. One of our major purposes is to help them to do better this task which the Medical Center alone could never accomplish.

It has taken more than four years from the time of the firm commitment to create a Medical Center to reach our present development, and our progress has been rapid as these projects go. Although much has been accomplished, it will be another four years, and probably more, before our program can be considered fully developed. Even more time will elapse before the physicians we educate can serve the communities of Kentucky and make their influence felt. We are engaged in a long-term development.

Although it has required much work and effort to reach our present point, we have had time to do careful planning and to recruit a staff of quality and distinction. Although these tasks are by no means finished, the progress to date promises well for the future.

If we are to achieve our objectives and aspirations, however, we must have your help in overcoming the many real and serious problems which lie ahead. We must have your understanding and at times your patience; we need also your forbearance in not asking us to do that which will compromise principle and quality for the temporary advantage of expediency.

Dedication to Future

In the light of our history and aspirations, this program must be primarily for the dedication of people and their commitment to this Medical Center and its purposes.

Therefore, we of the Medical Center staff today are dedicating ourselves to the service of this university in order to advance the health of our Commonwealth and nation. A university Medical Center is responsible for anticipating the future in the field of medical science and health services, and for preparing our people for their future. We expect to meet that responsibility by developing programs of such scope, quality and character that they will bring distinction to the university and to Kentucky. We aim to develop a Center in which you can take great pride and satisfaction. This we can and will do, given your continuing confidence and support.

As citizens and representatives of the people of Kentucky, you also have a responsibility at this time—to commit yourselves during this ceremony to the continuing support of this university and its Medical Center. If you will do this, together we can achieve our goals and aspirations and be the benefactors of generations to come. Together let us commission these fine new facilities and then dedicate ourselves and this Commonwealth to the achievement of these high purposes.

EDITORIALS

Polio—Whose Responsibility?

GIANT strides have been made in the fight against poliomyelitis in the last few years. In 1952 there were about 21,000 paralytic cases reported in the United States. In 1955 the Salk vaccine was introduced and by 1959 paralytic polio had declined to 6,289 cases, and to 2,265 cases in 1960.

Progress is being made but this crippling disease still is a serious health menace. There are too many people who are not vaccinated, and polio epidemics will be a threat until these people are immunized. A report from the United States Department of Health, Education and Welfare in 1961 showed that 38 per cent of children 5 years old and under, 63 per cent of men aged 20-40, and 48 per cent of women aged 20-40 are not fully vaccinated.

In 1960 almost half of the paralytic polio cases occurred in children 5 years old and under. It has been established that young adults who get polio are among those who become the most seriously paralyzed. It is essential, therefore, that we all work toward a successful 1961 polio vaccination campaign.

Oral polio vaccine will not be generally available in 1961 for any large scale program of immunization. The American Medical Association Board of Trustees has strongly recommended that doctors encourage their patients to take the Salk vaccine before the summer polio season. Salk vaccine is plentiful and has proved highly effective. Emphasis should be placed on infants and pre-school groups under 6 years of age, but every person should be fully immunized.

The keystone of any successful vaccination program is approval by the doctors in the community. Local campaigns should be the joint effort of medical societies, boards of health and voluntary health agencies. LET'S GET THE JOB DONE.

George W. Pedigo, M.D.

A Community Partnership

MAY 7-13 is National Hospital Week. This is a week set aside each year for the nation's hospitals and the communities they serve to become better acquainted. The theme this year is "Your Hospital—A Community Partnership."

The hospital answers the community health needs and it depends on the support of the community to maintain and expand its services. The medical profession should help the American Hospital Association promote this important public relations program and we as doctors should offer our assistance and full cooperation.

The magnitude of the service the hospital must provide for the community is easily understood when it is realized that one out of every eight people in the United States will receive hospital care in 1961.

Even though the most important service of the hospital is patient care, it should be realized that the hospital is a major community industry. The hospital provides a large number of jobs for people in the community. Doctors, nurses, dieticians, technicians, administrative personnel, secretaries, orderlies, cooks, laundry workers, housekeeping workers and engineering teams (to maintain heat, light and power) are all needed to operate an efficient hospital. It is estimated that as a group hospitals employ one and one-half million people. Two-thirds of the

hospital's annual expenditure goes to meet its payroll.

Hospitals are large consumers of electric power, using collectively two and one-half billion kilowatt hours of electrical energy a year. They also use sixty-three billion gallons of hot water annually. Each year more than two billion meals are prepared and served in our hospitals and about two and one-half billion pounds of ice are consumed.

We as physicians are concerned with criticism directed at any part of the medical team because of the rising cost of health care. We urge the hospitals to be self-critical and to search constantly for areas where greater efficiency can be effected without lowering their standard of personalized patient care. The public must realize, however, that a marked reduction in hospital costs is not possible without a reduction in either the number of services or the quality of services which hospitals provide.

The community must play its part in the vital partnership with the hospitals. As individuals, all citizens must have an understanding of the hospital's purposes and its goals. Community leaders are needed to serve on hospital governing boards. Young people must be encouraged to enter health careers. Volunteers are needed in all hospitals to provide many extra touches to patient care and to help lighten the load for busy hospital personnel. The hospital depends on the support, understanding and participation of the community.

We urge you to support your hospital. Keep informed of its plans, its problems and its progress. For a hospital to offer the very best in health care it needs the cooperation of an enlightened public, an interested and inspired medical staff, and a dedicated hospital administration staff.

George W. Pedigo, M.D.

A Pledge for Kentucky Physicians

I do solemnly swear that I will make every effort to attend the 1961 KSMA Annual Meeting in Louisville on September 19, 20, and 21—and with this pledge, I promise to take immediate action by:

1. *Circling September 19, 20, and 21 on my calendar*
2. *Making arrangements for another physician to handle my practice*
3. *Writing for hotel reservations, if needed*
4. *Notifying patients that I will be out of the office for purpose of adding to my medical "know-how"*

Recognizing that the objective of the Association's Annual Meeting is to contribute to my medical knowledge by providing a varied, interesting and valuable program of postgraduate medical education, I hereby pledge myself to take an active interest in all scientific sessions, exhibits, and in all phases of the program leading to the advancement of the KSMA and the profession of medicine.

ORGANIZATION SECTION

Colleges of Physicians, Surgeons Name Annual Meeting Speakers

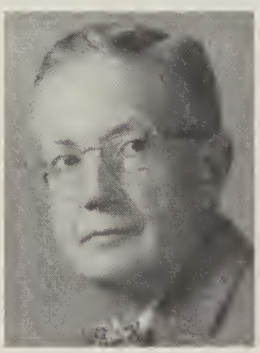
The Kentucky Chapters of the American College of Physicians and the American College of Surgeons have announced their guest speakers for the 1961 Annual Meeting of KSMA in Louisville, September 19-21. Each of the guest speakers will give a presentation before the general session and another before his specialty group.



General Blount

Brig. Gen. (MC) Robert E. Blount, Director of Professional Service in the Office of the Surgeon General, Washington, D. C., has accepted the invitation of the College of Physicians to participate in the Annual Meeting, according to Sam A. Overstreet, M.D., Louisville, governor of the Kentucky Chapter.

Charles Gardner Child, 3rd M.D., professor and chairman of the Department of Surgery, University of Michigan Medical School, Ann Arbor, will be the guest of the surgical group all day September 19 and the morning of September 20, announces Laman A. Gray, M.D., Louisville, president.



Dr. Child

General Blount received his M.D. degree from Tulane University Medical School in 1932. Entering active duty in 1933, he served as Assistant Chief of Medicine and then as Chief of the Outpatient Clinic at the Station Hospital, Fort Slocum, New York, and subsequently as Chief of Medicine at Fort Stotsenberg, Philippine Islands. In 1944-45 he commanded the 129th General Hospital in the European theater of operations. In 1947 he was sent to the Far East Command as Consultant in Medicine. In 1955 he began a 3½-year tour of duty as Consultant in Internal Medicine for the United States Army in Europe.

Doctor Child, a 1934 graduate of Cornell University Medical College, served that college as instructor in surgery and assistant and associate professor of clinical surgery from 1940 to 1953. He was professor and chairman of the Department of Surgery, Tufts University School of Medicine, from 1953 to 1958. A member of the ACS Board of Governors in 1958, he also holds membership in the American Surgical Association, the Society of Clinical Surgery and the Society of University Surgeons.

Dr. Brockman New AMA Delegate; Dr. Quertermous, Alternate

George F. Brockman, M.D., Greenville, was elected KSMA'S third delegate to the AMA by the Board of Trustees of KSMA at its April 5 meeting in Lexington. John C. Quertermous, M.D., Murray, was named alternate delegate for Doctor Brockman at the same time.

The two will serve through December 31, 1961. A delegate for the full two-year term starting January 1, 1962, will be elected by the KSMA House of Delegates at its regular annual meeting in September.

This is the first time KSMA has qualified for a third delegate since AMA started charging membership dues in the early 1950's.

The new delegate and alternate will represent KSMA at AMA's 110th annual meeting in New York, June 25-30, along with the association's other two delegates, W. Vinson Pierce, M.D., Covington, and Robert C. Long, M.D., Louisville, and their alternates, J. Vernon Pace, M.D., Paducah, and George P. Archer, M.D., Prestonsburg.

Highway Safety Committee Formed By KSMA Board of Trustees

A five-man Highway Safety Committee, headed by Arthur Keeney, M.D., Louisville, was appointed by the KSMA Board of Trustees at its meeting in Lexington April 5. The other members are Delmas M. Clardy, M.D., Hopkinsville; Arnold Griswold, M.D., and William Keller, M.D., Louisville, and Timothy Swartz, M.D., Lexington.

Recommendation that a committee on highway safety be formed was made by the KSMA House of Delegates at the 1960 Annual Meeting. Already functioning actively, the new unit is in the midst of getting information from physicians on the use of safety belts in automobiles.

The AMA long has been a leader in pressing for national legislation in regard to highway safety.



This famous skyline easily identifies the city that will be host to the American Medical Association's 110th annual meeting June 25-30. The last time the AMA met in New York was in 1957 when 23,888 physicians registered.

AMA Expecting 25,000 Physicians In New York, June 25-30

The American Medical Association's 110th annual meeting is expected to attract 50,000 persons, including 25,000 physicians, to New York City, June 25-30. Theme of this "world's fair of medicine" is "Teamwork in Medicine."

Some 2,000 physicians will take part in the scientific program and more than 300 will deliver lectures before 20 different scientific meetings. Teaching mediums will include lectures, symposiums, panel discussions, movies and closed-circuit television. In addition, there will be 827 technical exhibits and more than 350 scientific exhibits.

The meeting will open formally on Sunday, June 25, with a special preview luncheon and showing in the Coliseum for AMA officers and committee chairmen, members of the Board of Trustees, representatives of the Pharmaceutical Manufacturers Association, and invited guests.

Inauguration of the new AMA president, Leonard W. Larson, M.D., is scheduled for 8:30 p.m. Tuesday in the Waldorf-Astoria ballroom. The 63-year-old pathologist and clinic executive from Bismarck, N. D., will succeed E. Vincent Askey, M.D., Los Angeles surgeon.

Registration hours, Monday through Thursday, will be from 8:30 a.m. to 5:30 p.m. and until noon on Friday. Advance registration forms appear in JAMA (March 4 and 18, April 1 and 29 and May 13) and in April issues of all AMA specialty Journals.

The meeting will mark the eighth time the AMA has met in New York. The last time was in 1957 when 23,888 physicians were registered.

Internists to Meet May 26

The Kentucky Society of Internal Medicine has set its annual meeting for Friday, May 26, at the Campbell House in Lexington, according to Karl Crisler Kelty, M.D., Lexington, program chairman. A meeting of the executive committee at 5 p.m. will be followed by dinner at 7 and the evening session at 8. Speaker will be Don Giffin, Louisville, assistant director of the Blue Shield Plan.

Carl H. Fortune, M.D., Lexington, is president of KSIM and Robert L. McClendon, M.D., Louisville, is president-elect. The secretary is Ralph M. Denham, M.D., Louisville.

Dr. Rowntree Is New President Of Industrial Physicians

Gradie R. Rowntree, M.D., Louisville, took office as president of the Industrial Medical Association at the group's 46th annual meeting in Los Angeles, Calif., April 11-13. Named to succeed him in 1962 was Glenn Gardiner, M.D., Chicago.



Dr. Rowntree

Doctor Rowntree served three years on the executive committee of the 4,000-member national organization and twice on its board of directors. He was the first president of the Kentucky Industrial Association, organized in September 1959. He has been medical director of the Fawcett-Dearing Printing Company, Louisville, for 13 years and chairman of the Louisville-Jefferson County Board of Health the last five years. He also is professor of occupational medicine at the University of Louisville School of Medicine.

Doctor Rowntree said that the IMA under his administration will attempt to increase its membership, to interest more practicing physicians in the field of occupational medicine, to strengthen the educational side of organized medicine, and to improve the Journal of the organization.

The 1962 meeting of the industrial physicians is set for April 10-12 at the Pick Congress Hotel, Chicago.



J. Murray Kinsman, M.D., left, dean of the University of Louisville School of Medicine, accepts for the school a check for $9,327.32 from Robert L. McClendon, M.D., chairman of the AMEF Committee of KSMA. The gift was part of $1,172,599.60 contributed by physicians to AMEF during 1960 and distributed to 85 medical schools.

AMEF Makes $9,327 Grant To U. L. Medical School

A $9,327.32 gift to the University of Louisville School of Medicine was made last month by the American Medical Education Foundation—bringing to $43,123.32 the amount given to the school by AMEF in the last five years.

The presentation was made at a dinner meeting of the Jefferson County Medical Society in conjunction with the AMA Medicolegal Conference held in Louisville April 14-15. The check was formally accepted by J. Murray Kinsman, M.D., Medical School dean, from Robert L. McClendon, M.D., chairman of the KSMA Committee on AMEF.

The grant to the Louisville Medical School was part of $1,172,599.60 contributed by physicians to AMEF during 1960 and distributed to 85 medical schools across the nation.

AMEF grants represent but a portion of the money contributed annually by physicians to medical schools. In addition to its AMEF grant, the Louisville Medical School received $65,829.76 in direct gifts from its alumni, part of $4 million in total gifts reported by medical schools.

Rules Explained For Surrendering Undesired Narcotics

Regulations for surrendering excess and undesired narcotic drugs are explained by the Federal Bureau of Narcotics Agent in a communique received by Martin Niswonger, director of the Division of Investigation and Narcotic Control, Frankfort.

Such drugs may be shipped, prepaid express, to the District Supervisor, Bureau of Narcotics, 608 Federal Building, Detroit 26, Mich. No remuneration will be made for the surrendered items.

Form 142 titled "Registrant's Inventory of Drugs Surrendered" will be furnished upon request. This must be prepared in quadruplicate and mailed to the District Supervisor with a letter advising date of shipment of the drugs and describing the size of the carton. A receipted copy of the form will be returned for the registrant's files. The law requires that the receipt be kept for two years.

Form 142 may be obtained from Mr. Niswonger's office at 275 East Main Street, Frankfort.

David R. Upton, M.D., Munfordville, has announced his candidacy for Coroner of Hart County in the Democratic primary, May 23.



Approximately 350 physicians and attorneys attended the regional medicolegal symposium sponsored by the AMA in Louisville, April 14 and 15. One of the more interesting programs was provided by the above panel which discussed medicolegal landmark cases. Reading from left to right are the moderator of the panel, Mr. George E. Hall, Chicago, a member of the legal staff of the AMA; Mr. Harry W. Ginty, Fort Wayne, Ind., head of the legal department, Medical Protective Company; Wyatt Norvell, M.D., New Castle, vice-chairman of the KSMA Board of Trustees; Mr. E. Gaines Davis, Frankfort, KSMA legal counsel; Don Mills, M.D., Los Angeles, who also holds an L. L. B. degree; Karl F. Nygren, Chicago, a member of the firm that serves as legal consultant to the AMA.

12th, 15th Districts Meet June 1 At Cumberland Falls

Arrangements are complete for the June 1 joint meeting of the 12th and 15th Trustee Districts at Du-Pont Lodge, Cumberland Falls, announce Thomas O. Meredith, M.D., Harrodsburg, and Keith P. Smith, M.D., Corbin, respective trustees of the two districts.



Dr. Adams

Three medical specialists will present the scientific session starting at 3:30 p.m. At the dinner meeting, KSMA President Richard G. Elliott, M.D., Lexington, will speak and Charles B. Stacy, M.D., Pineville, will show color pictures taken on a trip to Africa.

Guest essayist will be John Q. Adams, M.D., associate professor of obstetrics and gynecology at the University of Tennessee Medical School, speaking on "Premature Separation of the Placenta." Doctor Adams will be presented under a grant-in-aid from the Merck Sharp & Dohme postgraduate program.

Two faculty members of the University of Louisville School of Medicine will be the other scientific speakers. Margaret A. Limper, M.D., associate professor of pediatrics, will present a paper, "Infantile and Juvenile Obesity" and James R. Hendon, M.D., assistant professor of medicine and chief of the Section on Endocrinology, will talk on "Thyroid Troubles."

Physicians with their wives are expected to attend from 18 counties. In the 12th District are: Boyle, Casey, Clinton, Garrard, Lincoln, Mercer, McCreary, Pulaski, Rockcastle, Russell and Wayne. Counties comprising the 15th District are Bell, Clay, Harlan, Knox, Laurel, Lesley and Whitley.

Second, Third Districts Announce Program for May 26 Meet

The program for the joint meeting of the Second and Third Trustee Districts May 26 at the Henderson Country Club has been announced by Walter L. O'Nan, M.D., Henderson, Second District Trustee, and Ralph D. Lynn, M.D., Elkton, Third District Trustee.

KSMA President Richard G. Elliott, M.D., Lexington, will be the featured speaker and two members of the faculty of the University of Louisville Medical School will present papers. Essayists and their subjects are: James B. Douglas, M.D., assistant professor of radiology, "X-Ray Helps for General or Specialty Practice;" and William Edward Oldham, M.D., assistant professor of obstetrics and gynecology, "Child Birth After Endometriosis."

W. H. Cave, M.D., Henderson, president of the Henderson County Medical Society, will preside at the dinner meeting which will begin at 6 p.m. with a social hour for doctors and their wives.

First District Meeting May 25 At Kenlake, Hardin

The First Trustee District has scheduled its annual dinner meeting for Thursday, May 25, at Kenlake, Hardin, according to Hugh L. Houston, M.D., Murray, trustee of the nine-county district.

KSMA President Richard G. Elliott, M.D., Lexington, will be the featured speaker. Sharing the program as essayist will be Henry B. Turner, M.D., associate professor of the Department of Obstetrics and Gynecology, University of Tennessee Medical School. He will present a paper, "Cancer Detection and Treatment In the Female."

Counties in the First District are: Ballard, Calloway, Carlisle, Graves, Fulton, Hickman, Livingston, Marshall and McCracken.

Fourth, Sixth Districts to Meet June 22 In Glasgow

The Fourth and Sixth Trustee Districts of KSMA have completed plans for their joint meeting in Glasgow, June 22, it is announced by Dixie E. Snider, M.D., Springfield, and John P. Glenn, M.D., Russellville, trustees of the respective districts. Members from 24 counties and their wives are expected to attend.



Dr. Cummins

Three medical-school faculty members will present the scientific session, starting at 2 p. m. at District Six State Tuberulosis Hospital. A social hour will be held at the Glasgow Country Club, after which the physicians will return to the hospital for the dinner program featuring KSMA President Richard G. Elliott, M.D., Lexington, as speaker and Charles B. Stacy, M.D., Pineville, in a showing of color pictures of his African trip.

Alvin J. Cummins, M.D., associate professor of the Department of Medicine, University of Tennessee College of Medicine, Memphis, will be the guest essayist. His subject will be, "Use of Steroids In the Management of Gastrointestinal Diseases."

The University of Louisville School of Medicine will be represented by two speakers. William T. Rumage, Jr., M.D., assistant professor of surgery, will present a paper on "Trauma Management for the G. P." and Glenn W. Bryant, M.D., assistant professor of obstetrics and gynecology, will talk on "Toxemia of Pregnancy."

Counties in the two KSMA districts are: Fourth District—Breckinridge, Bullitt, Grayson, Green, Hardin, Hart, LaRue, Marion, Meade, Nelson, Spencer, Taylor and Washington; Sixth District—Adair, Allen, Barren, Butler, Cumberland, Edmonson, Logan, Metcalfe, Monroe, Simpson and Warren.



PRACTICAL INSIGHT INTO MEDICAL PRACTICE was given the U. of L. seniors at the KSMA's Senior Day afternoon session at the Kentucky Hotel. The team of instructors included, from left: Oscar Hayes, M.D., Louisville; Carl Fortune, M.D., Lexington; John W. Ratliff, Jr., M.D., Lebanon; Jack Chumley, M.D., Louisville; Lillard F. Beasley M.D., Franklin, and Garnett J. Sweeney, M.D., Liberty. The annual event, honoring the senior medical students at the University of Louisville School of Medicine, is cosponsored by the Medical School and the Jefferson County Medical Society.

Senior Day Speaker Makes Plea To Keep Medicine Free

"If this is a sample of socialized medicine, I'm going on the stump to talk against it," resolved Chester Lauck, Houston oil company executive after a recent experience abroad.

And he did just that—as the Senior Day guest speaker in Louisville March 20.

The former radio star's introduction to socialized medicine came while he was in Yugoslavia on a film-making assignment for his company. When a member of his staff became ill, efforts were made to get a doctor. After an anxious wait of three days, one arrived. Diagnosis: appendicitis.



PRACTICING AND PROSPECTIVE PHYSICIANS got together for KSMA's Senior Day activities in Louisville March 20. Pictured at the opening program in General Hospital's Rankin Amphitheatre are, from left: KSMA President Richard G. Elliott, M.D., Lexington, the featured speaker; Coy Ball, president of the senior class of the University of Louisville School of Medicine; J. Murray Kinsman, M.D., dean of the U. of L. Medical School, and Carl C. Cooper, M.D., Bedford, chairman of KSMA Senior Day Committee.

"Why do we think this can't happen to us?" asked Mr. Lauck. It can, he said—"just like the little boy helping the old lady across the street when she doesn't want to go."

Challenging the physicians to stand up and be counted, he urged that they correct things at home by trying to persuade responsible persons to run for office, and by talking to their patients about politics and government. "If we turn to the government for everything, our democracy will be hopelessly lost," he warned.

Opening his address on a lighter note, the speaker—the former "Lum" of radio and movie fame—entertained his audience with numerous anecdotes.

The dinner program climaxed a day of activities honoring the senior class of the University of Louisville School of Medicine, which numbers 86 students. The annual event is sponsored by the KSMA, in cooperation with the Medical School and the Jefferson County Medical Society.

The program opened at noon with an address by KSMA President Richard G. Elliott, M.D., Lexington, delivered in the Rankin Amphitheatre of Louisville General Hospital.

Practical insight into medical practice was given the students by members of KSMA and a representative of AMA and Blue Cross-Blue Shield at the afternoon session held at the Kentucky Hotel. Carl Cooper, M.D., Bedford, chairman of the KSMA Senior Day Committee, presided.

The Jefferson County Society was host at the social hour and dinner, with each student a guest of an individual member.

Clyde L. Garr, M.D., Flemingsburg, plans to retire May 13 after practicing medicine in Fleming County for 51 years. He will continue as president of the Farmers Deposit Bank. Doctor Garr is a 1910 graduate of the old Medical Department, University of Louisville.



MORE POINTERS ON PRACTICE AND ALLIED INTERESTS were offered by these participants in the Senior Day afternoon program. Standing, from left: Ed McConnell, Louisville, vice-president of Blue Cross; Edward B. Mersch, M.D., Covington; George W. Pedigo, M.D., Louisville, and Joe D. Miller, Chicago, AMA field representative. Seated, from left: Carl C. Cooper, M.D., chairman of the KSMA Senior Day Committee; Donald Chatham, M.D., Shelbyville; Orson P. Smith, Jr., M.D., Louisville, and Wyatt Norvell, M.D., New Castle.



GUEST SPEAKER AND DINNER HOSTS posed for this picture before the start of the Senior Day evening program. From left: Carl C. Cooper, M.D., Bedford, chairman of the KSMA Senior Day Committee; Chester Lauck, Houston, Texas, speaker; Daniel Costigan, M.D., president of the Jefferson County Medical Society, host at the dinner, and George F. McAuliffe, M.D., chairman of the Jefferson County Senior Day Committee. Mr. Lauck, the former "Lum" of radio and movie fame, appeared through the courtesy of the Continental Oil Company of which he is executive assistant.

VA Hospital Announces Openings For Residents, Physicians

The Louisville Veterans Administration Hospital announces the opportunity for residency training in practically every specialty, as well as openings for two physicians to function as admitting physicians.

Residencies pay from $3,500 for first-year residents to $5,315 for fourth-year residents. Residency training in psychiatry and pathology can, under special arrangements, pay up to $10,635 per annum. All residency training programs are under the direction of the University of Louisville School of Medicine and include rotation through the other university hospitals.

The admitting physicians will have no ward responsibility. Duties consist mainly of examination and screening, and salaries can start at as much as $13,730.

For further information, please contact Dr. R. R. Kaplan, Director, Professional Services, Veterans Administration Hospital, Louisville 2, Kentucky.

Surgical Congress Picks Louisville

The Southern Surgical Congress has selected Louisville for its 30th Annual Assembly, March 2-5, 1962, according to J. W. Hancock, M.D., Louisville, past president of the Congress. Sessions will be held at the Brown Hotel.

The Congress is headed by Walter C. Jones, M.D., Miami, Fla. A. H. Letton, M.D., Atlanta, is the secretary-director.

W. M. Savage, M.D., Maysville physician and surgeon for twenty years, has joined the staff of the Murfreesboro, Tenn., Medical Clinic where he will specialize in general surgery. Doctor Savage, born in Weatherford, Okla., is a graduate of the University of Louisville School of Medicine and served as a flight surgeon with the Naval Air Service during World War II.



Morning speakers at the County Society Officers Conference in Lexington April 6 were introduced by KSMA President Richard G. Elliott, M.D., Lexington, who presided at the morning and luncheon sessions. From left are: Doctor Elliott; Norman A. Welch, M.D., Boston, Mass.; Raymond M. McKeown, M.D., Coos Bay, Ore., and Leo Brown, Chicago, director of the AMA Division of Communications.

Conference Speakers Sound Note For Action By Physicians

The health and well-being of our nation demand that physicians maintain a continuing program of participation in national affairs . . .

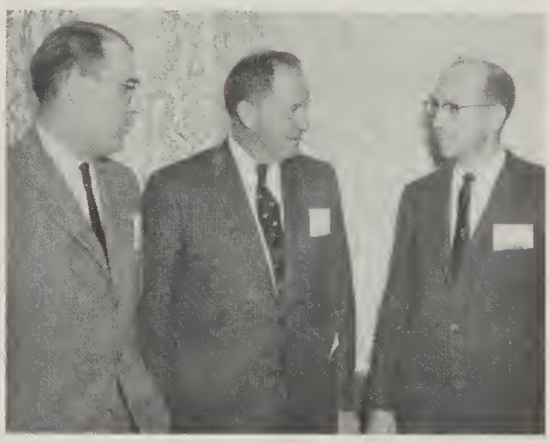
There are many things right with medicine that demand your defense . . .

Know what you're for and be *for* it . . .

We cannot stand still, nor can we assume an attitude of smug satisfaction . . .

These calls to action resounded from the speaking platform at the 11th Annual County Society Officers Conference in Lexington on April 6.

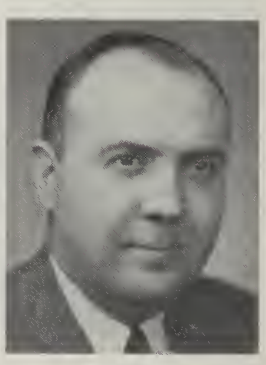
"I am just as bitterly opposed to socialized medicine as you are," declared the Honorable John C. Watts, Nicholasville, Congressman from Kentucky's Sixth District. But, he predicted, there's going to be some type of legislation on medical care for the aged, and it's up to the physician to get in and lead the parade.



Kentucky's Sixth District Congressman John C. Watts, center, Nicholasville, luncheon speaker at the conference, was greeted by the chairmen of KSMA's two legislative committees—George P. Archer, M.D., left, Prestonsburg, chairman for National Affairs, and Robert Shepard, M.D., Lexington, chairman for State Affairs.

The politician, like the doctor, is interested in promoting what the Preamble to the Constitution calls "the general welfare," said the Congressman. Therefore, "I urge you not to relax your efforts. Chart a course. Declare openly, vow publicly your opinions."

"The Federals are coming!" was the warning of a Paul Revere of 1961—Roger Fleming, secretary-treasurer and director of the Washington office of the American Farm Bureau Federation.



Mr. Fleming

The doctor and farmer, said Mr. Fleming, are faced with the same fundamental issue, that of centralized control versus individual freedom. The very concept of seeking an answer in government to every problem is a threat, he asserted. Pointing to the emotional appeals being made on all sides, he urged physicians to counter with an emotional sale as well as an intellectual one.

All available means of communication are being utilized by the opposition, and medicine finds itself with many town criers, Leo Brown, the AMA director of communications, told the Kentucky physicians.

"We are in an ideological war with a formidable adversary which can lose many times. *Medicine can lose only once,*" Mr. Brown stated emphatically. Thus it's up to the profession to speak out in behalf of and in defense of medicine, he said.

The voice of conscience of medicine spoke through Raymond M. McKeown, M.D., Coos Bay, Ore., chairman of the AMA Committee on Medical Discipline. After a two-year study, the committee has held the principle of state's rights to be paramount, the chairman reported.

Winslow Homer "THE HERRING NET" *Art Institute of Chicago.*



STRAIN

Strain is a necessary component of man's efforts to move his external environment, but all too often brings on extreme pain and trauma when hard stools are moved after repair of rectal disorders. Metamucil adds soft, bland bulk to the bowel contents to stimulate normal peristalsis and also hold water within stools to keep them soft and easy to pass. Thus Metamucil, with an adequate water intake, is of great help in minimizing painful trauma to postsurgical rectal tissue. Metamucil promotes regularity through "smoothage" in all types of constipation.

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CREMOSUXIDINE® [SULFASUXIDINE® SUCCINYLSULFATHIAZOLE SUSPENSION WITH KAOLIN AND PECTIN] reduces fluidity of stools, reduces enteric bacteria, adsorbs toxins, and soothes the irritated intestinal mucosa.

Chocolate-mint flavored...readily accepted by patients of all ages.

Additional information on CREMOSUXIDINE is available to physicians on request.

MSD MERCK SHARP & DOHME, DIVISION OF MERCK & CO., INC., WEST POINT, PA.

CREMOSUXIDINE AND SULFASUXIDINE ARE TRADEMARKS OF MERCK & CO., INC.

Doctor McKeown placed the responsibility for action on grievances in the county society, for "all of the committees of the AMA cannot improve the image of medicine if the societies do nothing." He urged societies to assume their obligations by appointing adequately-staffed grievance boards that would objectively and impartially resolve all issues for the best interests of all. "When medicine is castigated, there is new clamor for government to step in," he warned.

Norman A. Welch, M.D., Boston internist, speaking on behalf of Blue Cross-Blue Shield, told the conference that with the politician and labor leader demanding more comprehensive medical protection, "we must attempt to meet the reasonable expectations of the public." It will be necessary to give protection against long-term catastrophic illness as well as more services, and to see that utilization is not improper and not excessive, said the former chairman of the National Blue Shield Commission.

Reporting on a recent survey in Massachusetts, Doctor Welch said that 80 per cent of the persons questioned preferred the Blue Cross-Blue Shield type of protection.

Use of the many services of "your AMA" was urged by Joe D. Miller, Chicago, AMA field representatives assigned to cover five states including Kentucky.

Organized in 1847, the AMA now has 178,000 physician members and "stands firmly as a guardian of the public health," the former Kentuckian stated.

Richard G. Elliott, M.D., Lexington, president of KSMA, presided at the morning and luncheon sessions of the conference which was held at the Phoenix Hotel. Gaithel L. Simpson, M.D., Greenville, president-elect, was in charge of the afternoon meeting.

U. K. College of Medicine Now Has 11 Activated Departments

Eleven of the 13 academic departments of the new University of Kentucky College of Medicine have now been activated, with 45 faculty members on hand.

Forty medical students began classes at the $27,000,000 Medical Center last September. Eventual enrollment in the College of Medicine will be 75 students per year.

Department chairmen are:

Anatomy—William H. Knisely, Ph.D., former associate professor of anatomy and assistant professor of medicine, School of Medicine, Duke University.

Behavioral Science—Robert Straus, Ph.D., former associate professor of public health and preventive medicine, College of Medicine, State University of New York, Syracuse.

Biochemistry—George W. Schwert, Ph.D., former professor, School of Medicine, Duke University.

Community Medicine—Kurt W. Deuschle, M.D., former assistant professor of public health and preventive medicine, Cornell University Medical College.

Medicine—Edmund D. Pellegrino, M.D., former medical director and director of internal medicine, Hunterdon Medical Center, Flemington, N. J.

Pathology—Wellington B. Stewart, M.D., former associate professor, College of Physicians and Surgeons, Columbia University.

Pediatrics—John H. Githens, M.D., former associate professor, School of Medicine, University of Colorado.

Physiology—Loren D. Carlson, Ph.D., former professor, School of Medicine, University of Washington.

Psychiatry—Joseph B. Parker, Jr., M.D., former associate professor of psychiatry, School of Medicine, Duke University, and chief of Psychiatric Service, Veterans Hospital, Durham, N. C.

Radiology—Harold D. Rosenbaum, M.D., former radiologist of Lexington, Ky.

New Appointments

New appointments are:

Chairman and professor of surgery—Ben Eiseman, M.D., professor of surgery, School of Medicine, University of Colorado.

Associate professor of pediatrics—Frederick A. Horner, M.D., assistant professor, School of Medicine, University of Colorado.

Assistant professor in medicine—Alberto Mazzoleni, M.D., research fellow in cardiology at Beth Israel Hospital, Boston.

KDA Elects Ashland Dentist; Installs Louisvillian

Dr. R. M. Justice, Ashland, was named president-elect of the Kentucky Dental Association at the 101st annual meeting of the association in Louisville, April 9-12.



Dr. Buechel

Dr. E. J. Buechel, Louisville, took over the presidency, succeeding Dr. J. M. Dismukes, Jr., Paducah.

Other new officers elected by the association are Dr. Julian Harlowe, Louisville, first vice-president; Dr. Jack Weitlauf, Paducah, second vice-president; Dr. Clint Dowell, Louisville, sergeant-at-arms, and Dr. Ernest Ellison, Louisville, librarian.

Dr. Raymond E. Myers, dean of the University of Louisville School of Dentistry, and Dr. W. C. Cranz, Lexington, were named delegate and alternate delegate, respectively, to the American Dental Association. Dr. F. Sherman Vogt, Jr., Louisville; Dr. Howard Titsworth, Murray, and Dr. Harry Moore, Warrensburg, were chosen candidates for the State Board of Dental Examiners. Governor Combs will select one of the men to serve on the board.

AAGP Re-Elects Dr. Witten

Carroll L. Witten, M.D., Louisville, was re-elected speaker of the congress of delegates of the American Academy of General Practice at a meeting in Miami Beach, Fla., on April 18.

Postgraduate Offerings for Area Listed Through August

Tentative courses on Pediatrics, Chest Diseases and Medicine highlight the listings of the Postgraduate Medical Education Office for the next three-month period.

Scheduled dates and locations are: Pediatrics, June 8 in Owensboro; Chest Diseases, June 15 in Louisville; Medicine, July 13 in Harrodsburg. The programs are being submitted to the AAGP for acceptance for Category I credit.

Detailed information may be obtained from the Postgraduate Medical Education Office, 104 West Chestnut Street, Louisville 2, Ky. The telephone number is JUniper 7-7135.

The complete listing follows:

May

Weekly through 1961	One week training in the field of OB-GYN, each week during 1961, except May 15-20, October 2-7, and October 23-28, limitation of two physicians per week; fee of $50 includes room at General Hospital, if desired. Enrollment should be made at least two weeks before desired participation. Acceptable for 42 hours of AAGP Category I credit.
through May 23:	Postgraduate course, "Pediatrics"; Children's Hospital, Louisville, Tuesday mornings, 9:30 to 12:30; fee, $30 for the course or $5 per day. Acceptable for 24 hours of AAGP Category 1 credit.
17-18	Postgraduate course, "Neurology"; University of Tennessee, Memphis.
17-June 7	Jefferson County Academy of General Practice, Spring Seminar; Wednesday nights.
18-20	Kentucky State Ob-Gyn meeting; Netherlands Hilton Hotel, Cincinnati.
24-26	Postgraduate course, "Diagnosis and Treatment—Emotional Disturbances in Children"; University of Tennessee, Memphis.
25	First Trustee District meeting; Kenlake, Hardin.
26	Second and Third Trustee Districts, joint meeting; Henderson Country Club.

June

1	Twelfth and Fifteenth Trustee Districts, joint meeting; DuPont Lodge, Cumberland Falls.
8	Seventh Trustee District, meeting; Frankfort.
8	Postgraduate course, "Pediatrics" (Tentative); Owensboro.
14	Kentucky Academy of General Practice Seminar; Harrodsburg; John M. Baird, M.D., Danville, chairman.
15	Postgraduate course, "Chest Disease"; (Tentative), Louisville.
22	Kentucky Academy of General Practice Seminar; Henderson; Robert Sumner, M.D., Henderson, chairman.
22	Fourth & Sixth Trustee Districts, joint meeting; State TB Hospital, Glasgow.
26-30	AMA Annual meeting, New York City.

July

66	KAGP Seminar; Paintsville; George P. Archer, M.D., and James W. Archer, M.D., co-chairmen.
13	Postgraduate course, "Medicine" (Tentative); Harrodsburg.

August

16	Kentucky Academy of General Practice Seminar; Cumberland Falls; E. C. Seeley, M.D., London, chairman.
20	Kentucky Academy of General Practice Seminar; Lexington.

KHA Elects Col. R. E. Selwyn; Installs Homer Coggins

Col. Robert E. Selwyn, administrator of Harlan Memorial Hospital, Harlan, was named president-elect of the Kentucky Hospital Association at its annual meeting in Lexington, March 21-23, which drew a registered attendance of 1,042.

Installed as president was Homer D. Coggins, administrator of Central Baptist Hospital, Lexington. He succeeded Malcolm H. Black, administrator of District Six State Tuberculosis Hospital, Glasgow. E. W. Horgen, administrator of King's Daughters Hospital, Ashland, was re-elected treasurer.

The association also chose four administrators as trustees: E. L. King, Middlesboro Memorial Hospital; Harry R. Hinton, District Two State Tuberculosis Hospital, Louisville; C. H. Clark, Bowling Green-Warren County Hospital, and Ben R. Brewer, Western Baptist Hospital, Paducah. Selected as delegate and alternate delegate to the American Hospital Association were Otis L. Wheeler, director of Jewish Hospital, Louisville, and Richard D. Wittrup, administrator of University Hospital, Lexington.

Meeting in conjunction with KHA were the Hospital Auxiliaries of Kentucky, Kentucky Association of Medical Record Librarians, Kentucky State Association of Nurse Anesthetists, Kentucky Association of Hospital Engineers, Hospital Social Workers of Kentucky, Kentucky Chapter of National Executive Housekeepers Association and the three Kentucky Chapters of the American Association of Hospital Accountants.

The KHA set March 20-22, 1962, for its next meeting to be held at the Kentucky Hotel in Louisville.

William H. Cartmell, M.D., Maysville physician and surgeon, has been named to the executive committee of the Board of Directors of the Bank of Maysville.



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Heart Disease Symposium Has Registration of 349

A total of 349 physicians, including 19 faculty members, registered for the Seventh Annual Symposium on Cardiovascular Diseases, March 22-23, at the Brown Hotel in Louisville. Thirty-nine of these requested credit hours from the AAGP.

The program featured two past presidents of the American Heart Association. Irvine H. Page, M.D., Cleveland, Ohio, addressed the dinner meeting and also appeared as a panelist. Louis N. Katz, M.D., Chicago, was one of the essayists.

F. Albert Olash, M.D., Louisville, was named to head the program committee for the 1962 symposium. Jack L. Chumley, M.D., Louisville, served as this year's chairman.

The symposium is sponsored annually by the Heart Association of Louisville and Jefferson County and the University of Louisville School of Medicine.

Dr. Patricia Nicol Resigns Post With Health Department

Patricia Conlan Nicol, M.D., Louisville, has resigned, effective June 1, as director of the Bureau of Medical Services and Division of Medical Care in the State Department of Health. With the Health Department since 1957, she has been administering the medical phase of the indigent medical-care program since September 1960.

Doctor Nicol received her medical degree from the University of Louisville School of Medicine and was health officer of Harlan County from 1954 to 1957.

The former Patricia K. Conlan, she was married April 12 to Alan Nicol, M.D., physician with the United States Public Health Service leper hospital at Carville, La.

'Doctor's Day' Celebrations Held by Auxiliaries

"Doctor's Day"—March 30—was observed by many county medical society auxiliaries with special activities honoring the physician husbands of members.

Celebrating the day for the first time this year, the Whitley County Medical Auxiliary presented the physicians with red carnations and that night feted them with a dinner at DuPont Lodge at Cumberland Falls. The mayor of Corbin proclaimed it "Doctor's Day" in the city.

A dinner at the Henderson Golf and County Club topped off the observance for doctors in Henderson who also received the traditional red carnations as they made their hospital rounds. Each Pulaski County physician received a red carnation boutonniere to mark the day.

A "Doctor's Ball" honored Jefferson County doctors on January 21 at the Pendennis Club with each doctor attending receiving a red carnation. Physicians in Maysville were greeted by auxiliary members as they entered the hospital, were given carnations, and served coffee and rolls in their lounge. In Frankfort, "Doctor's Day" coincided with the regular monthly meeting.

The day is observed annually by many auxiliaries in memory of Crawford W. Long, M.D., who discovered the use of ether as an anesthetic on March 30, 1842, in Jefferson, Ga.

'Traveling Clinic' Examines Mason County Arthritics

At the invitation of the Mason County Medical Society, the "traveling clinic" of the Kentucky Chapter, Arthritis and Rheumatism Foundation went to Maysville March 16 and examined 37 arthritics referred by members of the society. Recommendations for treatment and therapy were made by the Louisville physicians who plan a follow-up visit in about five months.

The same plan is being followed in the case of arthritics in Laurel and Whitley Counties who were seen by the clinic in London last November. They will be examined again in May. The Kentucky Chapter offers its clinical services to any area of Kentucky where an invitation is given by a medical society, according to Gordon Huff, executive director.

Members of the clinic who made the trip to Maysville were: William P. Peak, M.D., president of the Kentucky Chapter; David H. Neustadt, M.D., chairman of the medical and scientific committee; Luis Spamer, M.D., acting medical director of the Rehabilitation Center; Marie Keeling, M.D., St. Joseph Infirmary, and Miss Mary McDonnell, physical therapist at the Rehabilitation Center.

Journal of KSMA Announces Staff Change

Mrs. Jean K. Buckby, who served on the staff of The Journal for the past several years, has resigned her position to become director of public relations for the Louisville and Kentucky Conferences of The Methodist Church.

Succeeding Mrs. Buckby as assistant managing editor is Mrs. Maleva Meyer, a graduate of the University of Missouri School of Journalism, who is experienced in this field.

The KSMA staff is grateful to Mrs. Buckby for her good work and extends its best wishes to her in her new work. It welcomes her successor, Mrs. Meyer, and feels she will become a valuable contribution to the success of The Journal.

Garfield Howard, M.D., has opened an office in Crab Orchard. After graduating in 1907 from the Old Hospital College of Medicine in Louisville, Doctor Howard went with the Southern Mining Company at Gatliff, where he remained until 1942. He next was with the Whitley-McCreary Health Department for three years, then with the Veterans Administration, Louisville, until September, 1960. During his long practice he has delivered almost 5,000 babies, all in homes. Doctor Howard is a native of Locke in Bell County.

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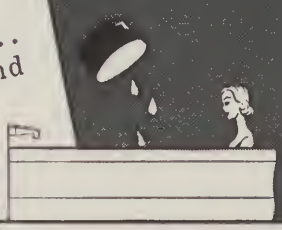
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Student AMA

The Matter of Medical Costs*

This is the case of a 33 year old white female, gravida 3, para 3, who was admitted to a private hospital in the Louisville area in April of 1961. The historian is a medical student who is an extern employed by the hospital to do histories and physicals. The informant is the patient. The provisional diagnosis as stated on the hospital admitting form was "duodenal ulcer."

Chief complaint: "I'm not sure why my doctor put me in the hospital; nervousness, I guess, because sometimes I don't feel too well. I think they are going to run tests on me."

Present Illness: Her complaints were vague and the details of her symptoms were not at all clear to the patient. Her "nervousness" began approximately six months ago when she went to work as a private secretary to increase the family income. She sometimes became nervous and upset when she returned from work and began preparing the evening meal for her husband and three children.

She further stated that her physician may have admitted her to the hospital because she occasionally experienced a "tired feeling" in her legs and lower back in the late evenings before retiring. This discomfort was mild and was relieved by rest and some "pills" her doctor had given her.

There was no history of changes in weight, no anorexia, abdominal pain, food intolerance, nausea or vomiting or change in bowel habits. There were no gastrointestinal complaints.

The family history, past history and social history were not remarkable.

Review of Systems: The review of systems was negative except for occasional mild frontal headache associated with "sinusitis" which occurs in the winter months. She had experienced numbness in both hands one day about 6 months ago.

Physical Examination: Physical examination revealed a well-nourished, well-developed individual whose vital signs were not remarkable. A complete physical examination was done and found to be negative.

The following studies were done: CBC, Urinalysis, Blood sugar, serum cholestoral, serum bibirubin, serum amylase and P.B.I. All were found to be within normal limits.

An upper and lower G.I. series was done, including a cholecystogram and chest X-ray. All were found to be normal.

She remained in the hospital for six days and was treated with seconal for rest and maalox suspension. She was discharged from the hospital with a definitive diagnosis of peptic ulcer and was placed on an ulcer diet.

The hospital bill alone amounted to $173.00. This was paid by her insurance company.

This is an actual case; one of many that any extern who works in a private hospital will see day after day.

In May of this year there will be a national meeting of the Student AMA in Chicago. Many questions concerning current trends in medicine will be discussed there. Among these questions will be: is there any solution to rising hospital costs? Can private insurance companies help solve the problem of rising medical costs?

Sometimes I wonder why my hospitalization insurance premiums are so high, don't you?

Barney E. Elliott, Jr.
President, Student AMA
University of Louisville

**Editor's note: To keep the cost of voluntary health insurance down, it is important for all of us to use it only in those cases which need hospitalization.*

Miss Sara Stice Elected By KPHA; Mr. Summers Takes Office

Miss Sara Stice of Frankfort, who helped organize the Kentucky Public Health Association 12 years ago, will become its head in 1962. She was named president-elect of the association at its annual meeting in Louisville April 10-12.

Director of the State Health Department's Division of Public Health Education for 12 years, Miss Stice has been a public-health worker for 17 years.

New president of KPHA is Thomas P. Summers, executive director of the Kentucky Tuberculosis Association. He succeeded Miss Ruth Spurrier, director of the Division of Public Health Nursing, State Health Department.

Other officers elected at the April meeting are: vice-president, Donald Colgan, sanitarian, Fleming County Health Department; directors, Mrs. Mary Louise Kalb, clerk, Bracken County Health Department, and Mrs. Shirley Spurrier, R.N., Owensboro-Daviess County Health Department.

The association's meeting was followed by a three-day convention of the Southern Branch of the American Public Health Association, also held in Louisville.

Student AMA Holds Election

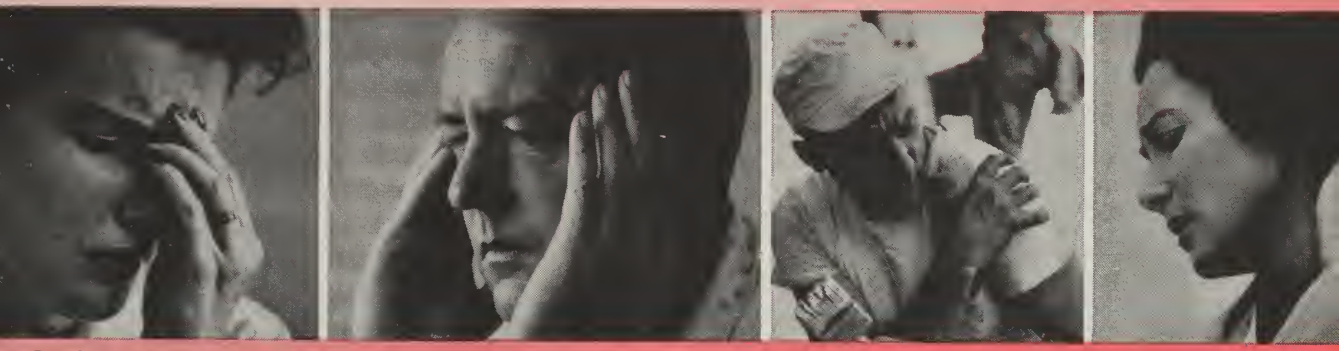
Olson Huff, class of 1962, was chosen as president of the Student AMA for the 1961-62 school year at recent elections by the University of Louisville chapter. Barney Elliott is retiring president.

Other officers are: Herbert Booth, class of 1962—vice-president; Terry Davis, class of 1964—secretary-treasurer; Olson Huff—delegate to the National Convention; and Rollin S. Burhans—alternate.

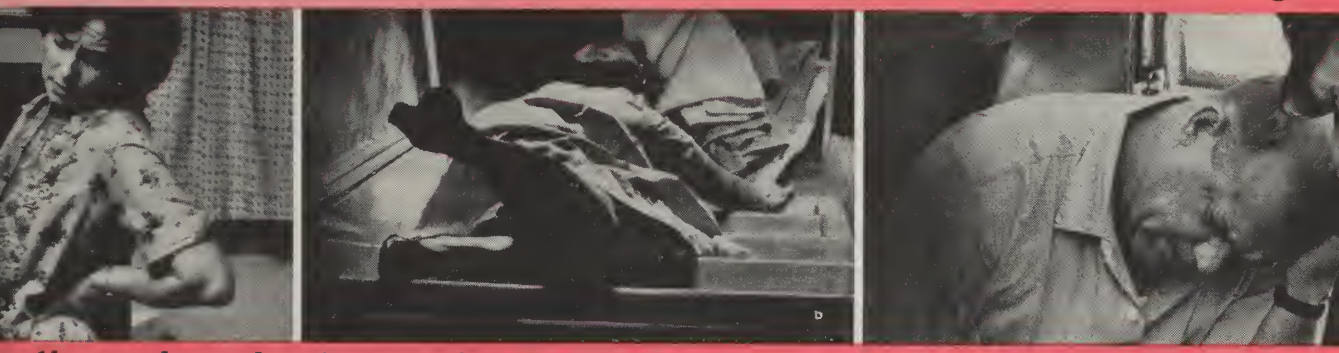
$16,000 For Medical Scholarship

The University of Kentucky College of Medicine has been allotted $16,000 in scholarship funds by the Avalon Foundation, largest U. S. contributor to medical education. The money will go into the college's planned scholarship program, according to William H. Knisely, Ph.D., chairman of the Student Affairs Committee and head of the Department of Anatomy.

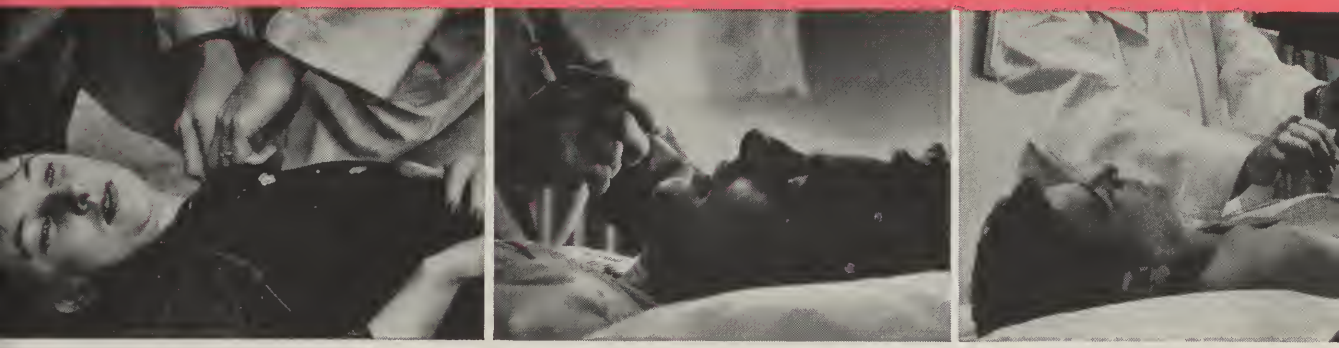
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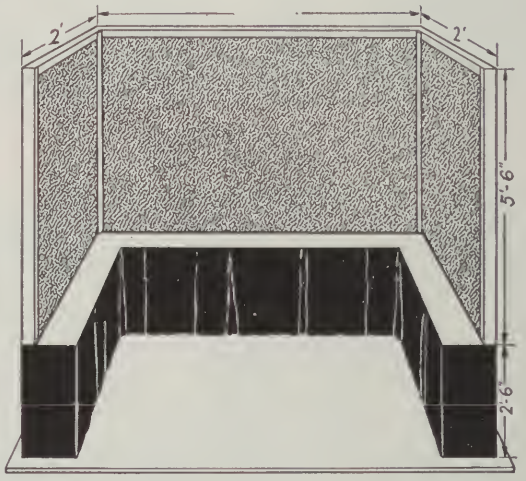
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4. Give approximate amount of wall space needed. (Included in total space is two side walls of two feet in length) .....

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The Kentucky State Medical Association will provide without cost to the exhibitor the following: Exhibit space, shelves, sign for booth, current, bracket lights, provided all items are approved in advance by the committee.

Cost of transporting exhibits to the meeting must be borne by the individual exhibitor as well as costs of cards, signs, etc., which are a part of the exhibit.

View boxes, furniture, decorations, etc., may be rented, if desired, by applying directly to Jos. T. Griffin Company, 704 West Main Street, Louisville 2, who supply equipment for the annual K.S.M.A. meeting.

KSMA Council, Committee Reports

School Health Committee

Carroll L. Witten, M.D., Louisville, Chairman

Kentucky Hotel, Louisville **February 16, 1961**

The Committee heard a report on the 1960 Athletic Injury Prevention Conference, held in Lexington, which pointed out that 141 coaches registered for the event.

Also, it was the opinion of the Committee that another conference should be held this year in conjunction with the Coaching Clinic, provided the KHSAA deems it proper that the conference should again be a part of this program. Following a suggestion from Richard G. Elliott, M.D., Lexington, KSMA president, the Committee also decided to look into the feasibility of holding a similar conference in Western Kentucky, provided it can be done with the approval and cooperation of the KHSAA.

One of the primary goals of this Committee for the coming year will be to stimulate interest among the physicians to serve as team physicians. Along this line, all county medical societies will be contacted to ask their cooperation.

In promoting this theme, an exhibit on athletic injuries was shown at KEA, April 5-7, with Fred V. Hein, Ph.D., serving as a staff person with the exhibit.

Public Health Committee

Delmas M. Clardy, M.D., Hopkinsville, Chairman

Brown Hotel, Louisville **March 23, 1961**

May 7-13 was approved as the period for the annual KSMA "Immunization Week" drive and it was agreed by the committee that the past procedures be followed in the promotion of this program.

Other action taken by this committee was to recommend that the AMA billfold-size health record cards be sent to all county society secretaries for free distribution and that the KSMA endorse the well child conferences as proposed by the State Department of Health.

Also, the committee discussed various points that the compulsory vaccination bill should cover in the 1962 session of legislature.

In compliance with the 1960 House of Delegates request on fluoridation, the committee recommended to the Council on Communications and Public Service that speakers kits on fluoridation be furnished the societies that are in unfluoridated areas. It was felt these kits could be effectively used in discussions of fluoridation merits.

An eight-week course in Occupational Medicine is announced by the New York University Postgraduate Medical School for September 18 through November 10. The course will cover the areas of preventive medicine, including epidemiology and biostatistics; administrative medicine, occupational diseases and industrial hygiene. For further information write: Office of the Associate Dean, NYU Postgraduate Medical School, 550 First Avenue, New York 16, N. Y.



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In Memoriam

EZRA V. SEAY, M.D.
Lawrenceburg
1872-1961

Ezra Vallandingham Seay, M.D., a practicing physician for 68 years, died April 4 at Haggin Memorial Hospital, Harrodsburg, at the age of 89. He retired in February after suffering a broken hip.

A native of Washington County, Doctor Seay received his M.D. degree from the University of Louisville Medical School in 1893. He started practice in Ashbrook, moving to Salvisa in 1905. He had lived in Lawrenceburg since 1948.

B. H. TODD, M.D.
Bowling Green
1924 - 1961

Benjamin Harris Todd, M.D., a member of the staff of the Graves-Gilbert Clinic, Bowling Green, died April 17, after an illness of a few days.

Doctor Todd, a native of Louisville, received his medical degree from the University of South Carolina Medical School, Charleston, S. C., in 1951 and practiced medicine at Lake View, S. C., for one year before moving to Bowling Green. He was 37.

WALTER DEAN, M.D.
Louisville
1883 - 1961

Walter Dean, M.D., Louisville eye, ear, nose and throat specialist, died March 27 in St. Louis where he was visiting. At 77, he still was active in private practice.

A native of Georgetown, Ind., Doctor Dean was graduated from the University of Louisville School of Medicine in 1909 and took postgraduate work in his specialty in London and Vienna. In World War I he served as an Army lieutenant at West Point. He was a retired professor of otorhinolaryngology at the U. of L. School of Medicine.

E. K. LAMB, M. D.
Franklin
1862 - 1961

Elzary King Lamb, M.D., retired physician of Franklin and emeritus member of KSMA, died April 9 at Bowling Green Hospital after suffering a broken hip. He would have been 99 on June 20.

Doctor Lamb practiced in Franklin for 65 years before blindness forced his retirement in 1955 at the age of 93. A native of Allen County, he operated a drug and general merchandise business in Tennessee in his early life. He was graduated from the Medical Department, Vanderbilt University, in 1893.

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T.B. Group Re-elects Officers

The Kentucky Tuberculosis Association has re-elected Theodore A. Sanford, Lexington, as president for the coming year. Also renamed were: vice-presidents, E. N. Maxwell, M.D., and Asa Barnes, M.D., both of Louisville, and W. Duane Jones, M.D., Ashland; secretary, Mrs. Chapman Jennings, Paducah, and treasurer, E. R. Gernert, M.D., Louisville.

Bluegrass Society KAGP Formed

The Bluegrass Society—the third component society of the Kentucky Academy of General Practice—was organized in January, according to J. S. Williams, M.D., Nicholasville, KAGP executive secretary. Jefferson County and the 14th District were the first of the Academy's 15 districts to set up component groups. Arnold Williams, M.D., Lexington, heads the new organization as its first president; Robert Sirkle, M.D., Lexington, is vice-president, and George Reed, M.D., Versailles, is secretary-treasurer.

Dr. Hess, Former AMA Head, Dies

Elmer Hess, M.D., former president of the American Medical Association, died March 29 in Erie, Pa. The noted urologist, 71, was founder of the urology clinic at Erie's St. Vincent Hospital.

Doctor Hess had spoken at various KSMA activities, including the County Society Officers Conference, President's Luncheon and Senior Day.

Cardiac Massage Topic May 23

William R. Milnor, M.D., associate professor of medicine at the Johns Hopkins University Hospital, Baltimore, will speak at 8 p.m. May 23 in the Rankin Amphitheatre of the Louisville General Hospital. His lecture on "External Massage and Electrical Defibrillation of the Heart" will be sponsored by the House Officers Association of the hospital. All physicians are invited to hear the address on the recently developed technique of external cardiac massage.

Wreno M. Hall, M.D., has opened an office in Elizabethtown for the practice of general surgery. A native of Cecilia, Doctor Hall was graduated from the University of Louisville School of Medicine in 1950, interned at Good Samaritan Hospital, Lexington, and served a five-year residency with the Veterans Administration, Louisville. He was in general practice in Mt. Sterling from 1951 to 1954 and in Louisville from 1959 to January 14 of this year. His military service includes three and a half years in the U.S. Infantry, with the rank of captain.

Ray H. Hayes, M.D., has resigned as district psychiatrist of the Community Services Division, State Department of Mental Health, to enter the U. S. Public Health Service. Doctor Hayes pioneered in establishing a mental health program in eastern Kentucky. He has had his headquarters at the Lexington Mental Health Center since 1957.

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County Society Reports

McCracken County

The McCracken County Medical Society devoted its February meeting to a discussion of old age medical care under the Social Security System and how the society could best make its views known to the Congress through talks to local civic, church and P.T.A. groups. Speakers included Drs. Johnson, Pace, Turner, Spaulding, Kleckner and Abell.

The secretary, William H. Smith, M.D., was instructed to write to AMA headquarters in Chicago for all available material on presenting the problem of "Social Security medicine" to the people.

Muhlenberg County

James Lynn Craig, M.D., Greenville, was elected to membership by the Muhlenberg County Medical Society at its April meeting. The Tennessee Valley Authority has stationed Doctor Craig as plant physician during construction of the Paradise Steam Generation Station, Paradise, Ky.

George F. Brockman, M.D., Legislative Key Man, reported on the County Society Officers Conference in Lexington. Information on the Kerr-Mills and King-Anderson Medical Care plans was presented and detailed consideration was given to the Kentucky Medical Care Program. A Speakers Bureau and a newspaper advertising program were organized by the society.

Sixth District

The relation of medicine to the problem of aging was the topic of the Sixth District Medical Society, meeting in Bowling Green on March 14. Guest speaker was Thomas Frist, M.D., Nashville, Tenn., who represented his state at the White House Conference on Aging. The Warren-Edmonson-Butler County Society was host at the meeting.

A joint meeting of the Sixth and Fourth Districts is scheduled for June 22 at District 6 Hospital, Glasgow.

Dr. Kamp Quits Health Post

Maurice Kamp, M.D., Louisville-Jefferson County health director since July 1955, has resigned to accept a similar position in Charlotte, N. C. He began his new duties as director of the Charlotte-Mecklenberg County Health Department on May 1. Doctor Kamp came to Louisville from Chicago, where he had supervised venereal-disease control for the U. S. Public Health Service.

His successor, named acting health director, is Thomas S. Wallace, Jr., M.D., who had been serving as director of tuberculosis control for the board. Doctor Wallace is a 1951 graduate of the University of Louisville School of Medicine.



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Nursing Homes Unit Elects

The Kentucky Association of Nursing Homes, meeting in Louisville April 12, elected Mrs. Ann Ralph, Lyndon, as its new president. She succeeds Mrs. Elizabeth Baxter, Louisville.

Other new officers are: Mrs. Beulah Miller, Frankfort, first vice-president; Mrs. Helen Piper, Paducah, second vice-president; Mrs. Nellie Atcher, Louisville, third vice-president; Mrs. Bernice Sisk, Madisonville, secretary; Jack Bousman, Louisville, treasurer, and Ira O. Wallace, Newcastle, governing council member.

Ob-Gyn Society Meets May 18-20

The Kentucky Obstetrical and Gynecological Society will convene Thursday morning, May 18, at the Netherland Hilton Hotel in Cincinnati for its 14th annual meeting. The conference will be in session until noon Saturday.

A complete program of the meeting was carried in the April issue of The Journal of KSMA.

Dr. Erwin Wins Grant to Italy

Edmond F. Erwin, M.D., professor of medical psychology at the University of Louisville School of Medicine, has been awarded a Fulbright grant to Milan, Italy. He will leave in September to lecture on behavioral science in medical education at the Catholic University of the Sacred Heart. The grant is for nine months.

Pediatric Group Hears Dr. Ward

J. J. Glaboff, M.D., president of the Kentucky Pediatric Society, presided at its April 19 meeting at the Brown Hotel, Louisville. Members heard a talk on "New Developments in Viral Hepatitis," given by Robert Ward, M.D. physician-in-chief of Children's Hospital, Los Angeles, and professor of pediatrics at the University of Southern Californria School of Medicine.

Dr. White Gets $9,512 Grant

Arthur C. White, M.D., assistant professor of medicine at the University of Louisville School of Medicine, has been awarded $9,512 by the National Tuberculosis Association to continue a study of tubercle bacilli. His project is titled "Lysogeny and Transduction with Mycobacteriophages." The grant was one of 33 made possible by Christmas Seal contributions.

The National Association of Blue Shield Plans, Chicago, announces that enrollment in the nationwide Blue Shield Plans reached 47,084,988 at the end of 1960, representing a membership of one out of every four Americans and nearly 15 per cent of the Canadian population. Kentucky Physicians Mutual, Inc., reports a membership of 702,028 at the end of 1960, with over $6,000,000 paid to doctors for their services.



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1. Barden, F. W., et al.: J. Maine M. A. 46:99, 1955.
2. Ford, R. A., and Blanchard, K.: Journal-Lancet 78:185, 1958.

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KSMA Has 11 New Members

KSMA has added 11 new members since The Journal's last report. They are:

William J. Beckmeyer, M.D., Ft. Thomas
Carl J. Brueggemann, M.D., Covington
John C. Davenport, M.D., Paris
Robert G. Draime, M.D., Newport
Roger Haas, M.D., Newport
Clare C. Hugan, Jr., M.D., Covington
John L. Jenkins, M.D., Henderson
Sheldon Kessler, M.D., Henderson
Douglas W. McKay, M.D., Covington
Richard J. Menke, M.D., Covington
M. G. Veal, Jr., M.D., Henderson

Surgeons Elect Dr. Ray

Edward H. Ray, M.D., Lexington, was elected president of the Kentucky Chapter of the American College of Surgeons at its annual meeting in Louisville, March 24-25. He succeeds Laman A. Gray, M.D., Louisville.

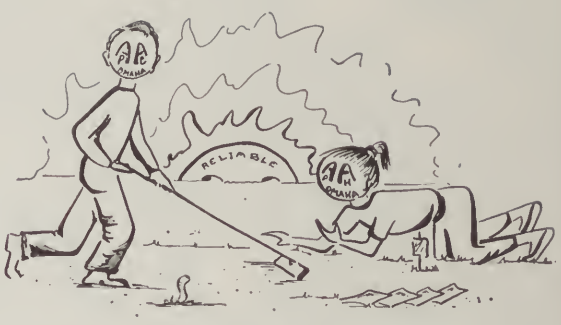
Also elected were Laurence M. Quill, M.D., Newport, vice-president, and Richard F. Grise, M.D., Bowling Green, councilor. Some 200 members and guests attended the college's two-day meeting.

Industrial M.D.'s Elect Dr. Allen

Charles E. Allen, Jr., M.D., Louisville, was named president-elect of the Kentucky Industrial Medical Association at the group's second annual conference and clinical meeting March 23 at General Electric Company's Appliance Park. Charles F. Martin, M.D., Lexington, was installed as president to succeed Eugene H. Kremer, M.D., Louisville.

Other officers elected were Frederick P. Shepherd, M.D., Louisville, vice-president, and Donald B. Thurber, M.D., Louisville, secretary-treasurer. Tom J. Smith, M.D., Louisville, was named a director.

Ray H. Hayes, M.D., has assumed the duties of associate chief of the Psychiatric Section, Department of Psychiatry, United States Public Health Service Hospital, Lexington. Doctor Hayes was formerly district psychiatrist with the Kentucky Mental Health Department's Division of Community Services.



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T. G. Perkins, M.D., has opened an office in Kuttawa, after practicing in Paris and the Lexington Signal Depot. Doctor Perkins, a native of Washington County, received his M.D. degree from the University of Louisville School of Medicine in 1957 and interned at City Hospital, Springfield, Ohio. He served in the U. S. Army.

The Trudeau School of Tuberculosis and Other Pulmonary Diseases has set June 5-23 for its 46th session in Saranac Lake, N. Y. This annual postgraduate course for physicians, conducted under auspices of the Trudeau Foundation, is supported by the Hyde Foundation and is offered at a minimal tuition of $100 for the three-week session. As enrollment is limited, applications should be made early. Address: Secretrary, Trudeau School of Tuberculosis and Other Pulmonary Diseases, Box 670, Saranac Lake, N. Y.

The 15th Annual Rocky Mountain Cancer Conference will be held July 12 and 13, at the Brown Palace West, Denver, Colo. Panel discussions on "Detect Cancer in Time!—Procedure, Problems and Solutions," and "Neoplasms of the Female Genital Tract," will be featured. Presidents of both the American Cancer Society and the American Medical Association will participate. Application has been made for AAGP accreditation for the conference. Further information may be obtained by writing Rocky Mountain Cancer Conference, 835 Republic Building, Denver 2, Colo.



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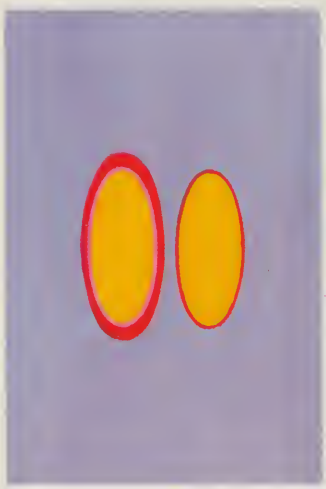
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Smooth, balanced action lifts depression as it calms anxiety...rapidly and safely

Balances the mood — no "seesaw" effect of amphetamine-barbiturates and energizers. While amphetamines and energizers may stimulate the patient — *they often aggravate anxiety and tension.*

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In contrast to such "seesaw" effects, Deprol's smooth, *balanced* action lifts depression as it calms anxiety — both at the same time.

Acts swiftly — the patient often feels better, sleeps better, within a few days. Unlike the delayed action of most other antidepressant drugs, which may take two to six weeks to bring results, Deprol relieves the patient quickly — often within a few days. Thus, the expense to the patient of long-term drug therapy can be avoided.

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THE MANAGEMENT OF THE DOCTOR-PATIENT RELATIONSHIP: by Richard H. Blum, Ph.D.; published by McGraw-Hill Book Company, Inc., New York, 1960; 304 pages, price, $8.50.

"Doctor-patient relationship" is a term now often seen in newspapers and magazines and heard in political, medical and lay discussions. It is a subject which very few physicians have considered thoughtfully and deeply, yet it is basic to the successful private practice of medicine. This book, as described in the preface, "is a research-based, practical, understandable, how-to-do-it book on the management of the physician-patient relationship."

The book may be divided into sections on the patient, the office call, the hospitalized and the surgical patient, the patient's family, the doctor himself, and a final brief chapter on Medical Public Relations.

Each section analyzes from a psychological and practical aspect the factors which make for good or bad feeling between the patient and his physician. The chapters on the uncooperative and the unreasonable patient are most interesting and informative, while that on hospitals and hospitalization is often revolutionary in its ideas.

This is a readable and interesting book. As in almost all psychologically-oriented writing, application of the methods advocated in the book would be too time consuming to be applied completely in a busy practice, but the character analysis of the patient and many of the author's approaches to common everyday problems could be used readily with benefit to both physician and patient.

I recommend this book to the resident and young practitioner just beginning his practice and to any other physician who wishes to shake up some of his present ideas and add interest and a broader perspective to his daily work.

Richard G. Elliott, M.D.

SIGHT, A HANDBOOK FOR LAYMEN: by Roy O. Scholz, M.D.; published by Doubleday & Company, Inc., Garden City, N. Y.; 1960, 166 pages; price, $3.50.

Dr. Scholz, the author of "Sight, A Handbook For Laymen," is an eminent ophthalmologist from Baltimore, Md., who, as well as being Chief of Service of the Department of Ophthalmology in several hospitals around Baltimore, is currently Ophthalmologist-in-charge at the Johns Hopkins Dispensary. In his own words, the book's purpose is to "answer the many intelligent questions patients ask their eye doctors. As the answers are frequently complex, it was designed to enable the patient, at his leisure, to gain a broad, non-technical view of the functioning of the eye in health and disease. It is not intended as an aid to diagnosis, but to give the layman a better understanding of the problem of vision."

The book is well arranged and written in a language that can be understood readily by most everyone, even though the reader has had no medical training or experience.

There are thirteen illustrations of general eye structure and refractive and optical principles, involving the normal and problematical states of the eye. There are also lucid discussions of the physiological factors of partial blindness, the advantages of early diagnosis and treatment of eye troubles in children, advances in treating injuries, optical aids, and contact lenses. In the last four pages of the book, there is a glossary of terms which gives clear and concise definitions of the most commonly used terms in eye disease.

I feel that this is a useful book and am sure that it will be of distinct value to nurses, public health workers and teachers. I feel, too, that it would be a worthwhile addition to the office library of opthalmologists, pediatricians and general practitioners for the purpose of reference by their patients or patients' families. Also, I think that this book should be included in every public school library for student and teacher reference.

Charles O. Bruce, M.D.

INFECTIOUS DISEASES OF CHILDREN: 2nd edition, by Saul Krugman, M.D., and Robert Ward, M.D.; published by The C. V. Mosby Company, St. Louis; 398 pages; price, $13.

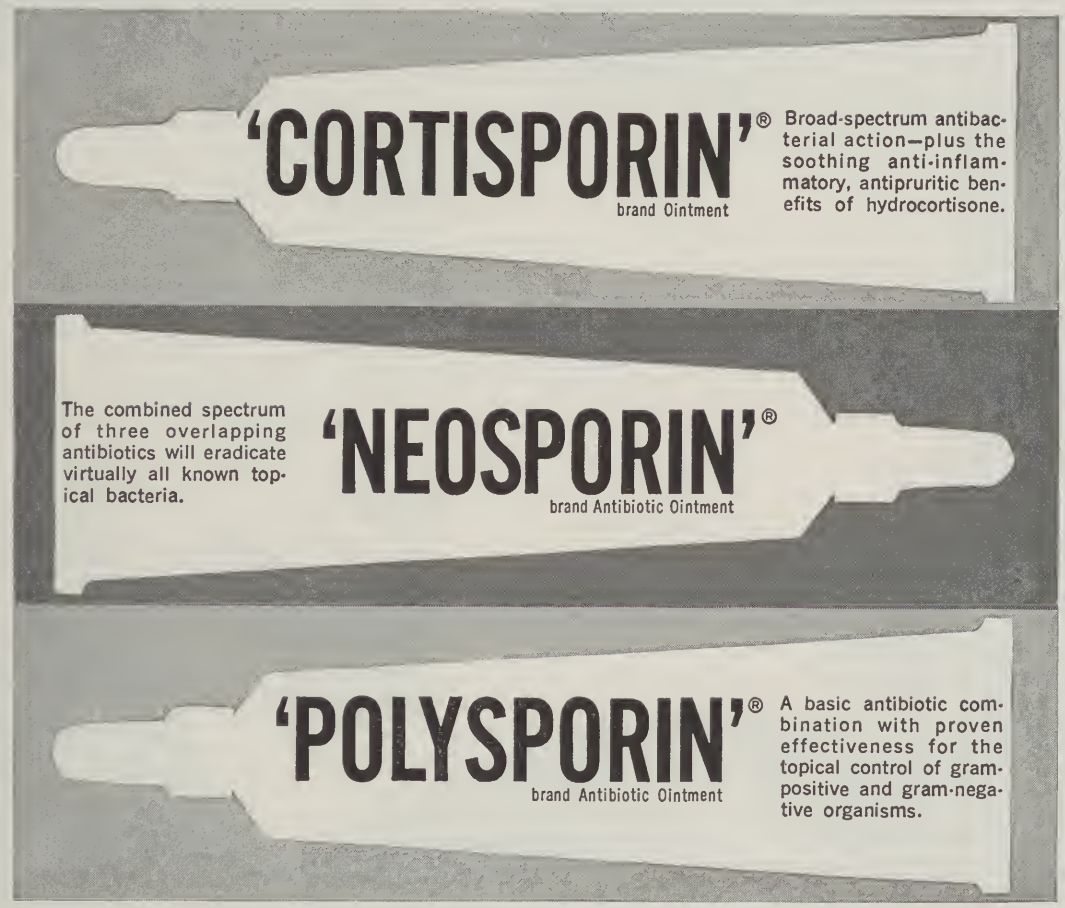
The first edition of this excellent book preceded the present one by only two years. The authors are to be highly commended for having responded so quickly to the need for revision brought on chiefly by the increased knowledge of viral agents and by new experiences with antibiotics for bacterial infections of childhood.

The book is authoritative, its authors being well experienced in the clinical and laboratory aspects of their subject. The numerous illustrations, charts and tables, together with systematic presentation of material, make this probably the most up-to-date, authoritative, clearly-written American text of its size on the subject.

The text is not intended to be all inclusive; thus, there are no chapters on tuberculosis, syphilis, the leptospiroses yellow fever, malaria and fungal diseases. Nevertheless, in less than 400 pages, including an excellent index, the text fulfills its intention most admirably.

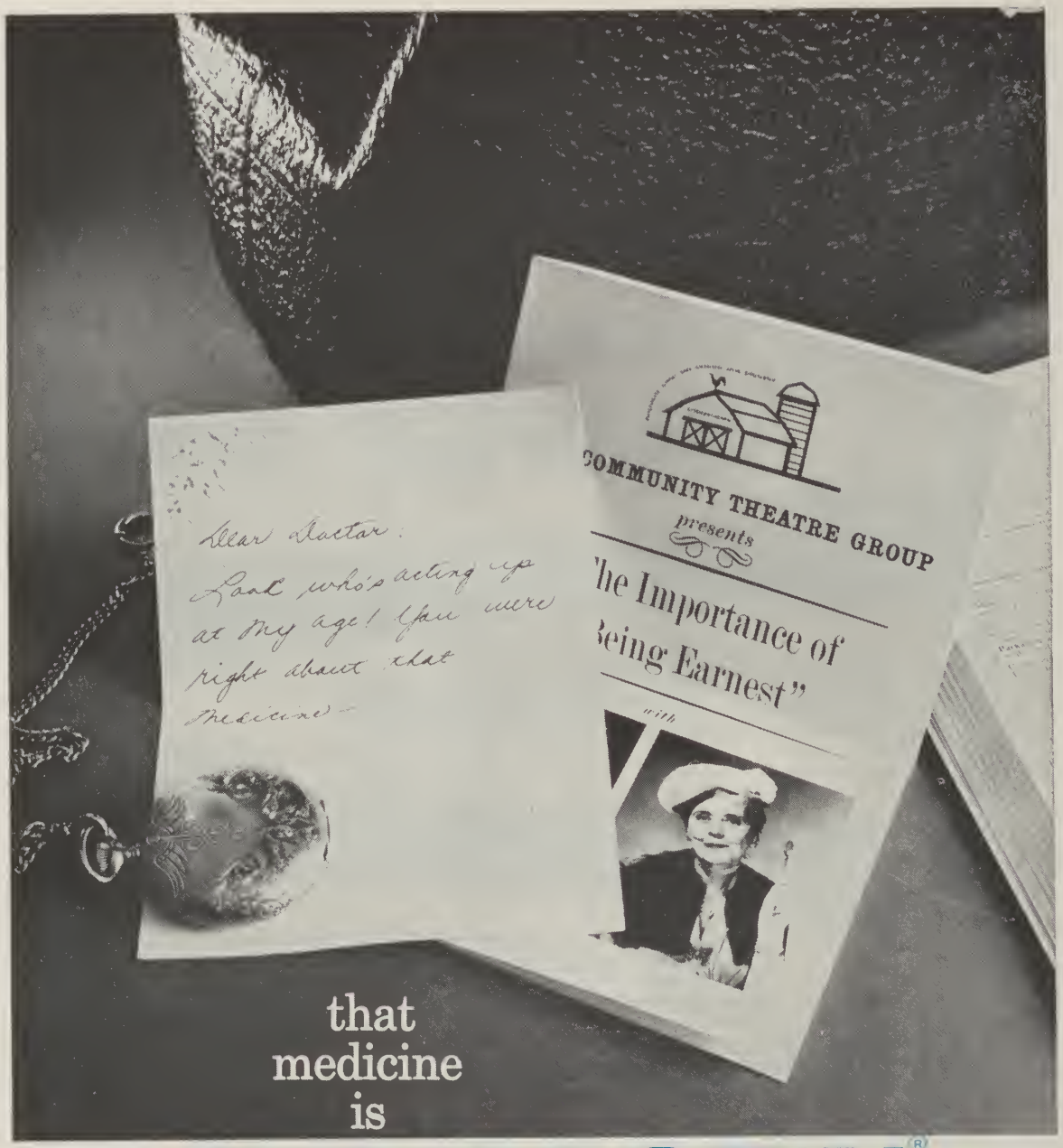
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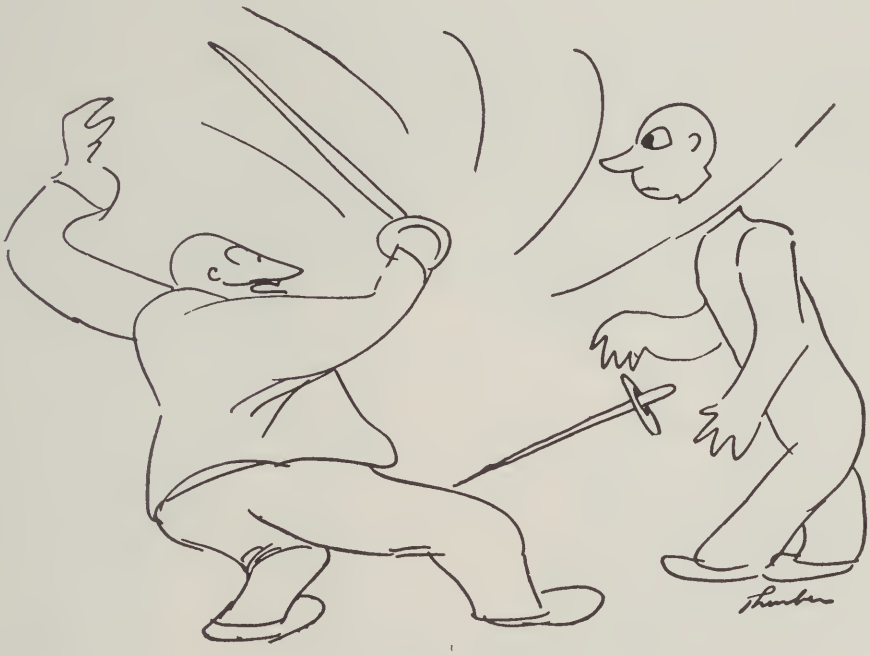
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COMMITTEE FOR THE
STUDY OF MATERNAL MORTALITY



CASE # 78a—A 34 year old white gravida 2 para 1 who had been under the care of a private physician, and whose expected date of delivery was December 13, 1959, was admitted to the hospital at 7 a.m. on December 21, 1959, shortly after the spontaneous onset of labor. Physical examination on admission showed the membranes to be intact; the cervix was completely effaced and dilated to 2-3 centimeters. The fetus lay in cephalic presentation, and engagement had taken place. The fetal heart rate and maternal blood pressure were normal.

The attending physician who was consulted by telephone, ordered 75 milligrams of phenergan intramuscularly, 50 milligrams of demerol and 0.4 milligrams of scopolamine intravenously, since the uterine contractions were occurring every three to four minutes, and lasted 30 to 40 seconds. The medication was not given because of an administrative error.

Between 8:30 and 8:45 a.m., the cervix was 3½ fingers dilated, and labor was progressing rapidly. The physician was again called, and the nurse administered the previously ordered medication. The membranes ruptured spontaneously while the patient was lying on her side as the intramuscular injection was being given. When the patient tried to roll on her back, the nurse noticed that she was gasping for breath and becoming cyanotic.

Another obstetrician who was present in the delivery area was quickly called. He described the patient as appearing possibly to be having a convulsion, although he saw no true convulsive seizure. Frothy fluid was seen issuing from the mouth, and the patient was cyanotic and unconscious. Both maternal and fetal heartbeats could still be heard.

An anesthesiologist was immediately called and an airway was inserted. The chest was promptly opened for cardiac massage with the assistance of a thoracic surgeon who happened to be in the hospital.

An emergency cesarean section was performed at 8:50 a.m. At the time of delivery, the infant was depressed and the amniotic fluid was stained, but within a few minutes the baby was crying and showed good color and normal respiration. The time lapse from the onset of maternal distress to delivery of the infant was approximately seven or eight minutes. After about fifteen minutes of cardiac massage, a very faint cardiac impulse was obtained.

While the incision in the uterus was being closed, the operator noticed that the patient's blood was not clotting normally. A tentative diagnosis of afibrinogenemia secondary to amniotic fluid embolism was made, and both fibrinogen and all the 0 Rh negative blood in the hospital bank was sent for. Since there was no 0 Rh negative blood in the bank, 0 Rh positive blood (the patient was Rh positive) was administered without cross-matching in view of the emergency. Within a period of about ten minutes, the patient received 2000 cc of blood and 2 grams of fibrinogen. No more blood or fibrinogen was obtainable.

The cardiac impulse never rallied, and the heart once again stopped beating completely. After about 60 minutes of unsuccessful cardiac massage, the patient was pronounced dead at 10 a.m.

At autopsy, the gross diagnoses were recorded as status following postmortem cesarean section and thoracotomy for cardiac massage, with pulmonary atelectasis, subinvolution of the uterus, and probable amniotic fluid embolus. The microscopic diagnoses included pulmonary amniotic fluid embolism, multiple small areas of pulmonary infarction, and subinvolution of the uterus.

Comments

The Committee classified this as a direct, nonpreventable obstetrical death. Amniotic fluid embolism can totally deplete the blood fibrinogen in a few minutes, and the case in question seems to illustrate this point. Even though the patient was treated in a well-staffed hospital and specialists were available for carrying out heroic measures, it was not possible to save the life of the mother.

When an emergency operation is indicated in the obviously moribund patient, certain medicolegal considerations are pertinent. Written consent should be obtained before performing surgery whenever this is possible; however, physicians are permitted by law to act in an emergency if appropriate relatives are not available to give permission. At the other extreme, failure to perform a postmortem cesarean section with death of the unborn infant could conceivably be considered as criminal neglect, since the obligation to save a life is fundamental, and no one should knowingly allow an unborn infant to die.

This entire question was epitomized as follows by Bacon in 1910: "A cesarean section made before life ceases to exist would not be at the discretion of the physician and certainly could not be justified if done without the husband's consent." After death, however, the rights of the child become paramount, and operation can be performed without consent and even against the husband's will without fear of legal reprisal.

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how would you design a tranquilizer specifically for children?



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efficacious	"... Atarax appeared to reduce anxiety and restlessness, improve sleep patterns and make the child more amenable to the development of new patterns of behavior...."[1]
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References: 1. Freedman, A. M.: Pediat. Clin. North America *5*:573 (Aug.) 1958. 2. Nathan, L. A., and Andelman, M. B.: Illinois M. J. *112*:171 (Oct.) 1957. 3. Santos, I. M. H., and Unger, L.: Ann. Allergy *18*:179 (Feb.) 1960. 4. Litchfield, H. R.: New York J. Med. *60*:518 (Feb. 15) 1960.

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PUBLIC HEALTH PAGE

An Evaluation Center for Retarded Children*

RUSSELL E. TEAGUE, M.D., M.P.H. *Commissioner of Health Commonwealth of Kentucky*

FOUR years ago, on this page, the need for a special diagnostic center for retarded children was proposed. At that time we announced our intention of opening such a center at Children's Hospital in the near future. For various reasons, however, we did not succeed in establishing the center until one year ago.

On March 28, 1960, the first child was admitted to Children's Hospital for this service.

Since that time 36 patients have been seen. Their ages range from 15 months to 15 years. Diagnoses include a variety of conditions; tuberous sclerosis, phenylketonuria, and one case of congenital syphilis! In the majority of instances some complication of the prenatal or birth period is implicated and brain damage due to anoxia or birth injury is the commonest diagnosis. It is interesting to note that only one of the 36 cases has been termed "familial."

Most noteworthy of all, perhaps, are those cases which have been mistakenly labeled "retarded" but where it is found that some other defect, e. g., hearing deficiency or emotional disturbance, is responsible. There have been four such cases, one of which was deemed due to malnutrition and neglect! These children can live a normal existence with correction or alleviation of their defect. However, it is our belief that a great contribution is made, even in the case of the truly retarded child, by the helpful counseling which is provided the parents or guardian by the clinician, the social worker and the public health nurse.

All diagnostic services of the program are provided free of charge to the patient, except in instances where he is covered by hospitalization. The costs are borne by the Bureau of Maternal and Child Health of the State Health Department.

The services provided by the center are as follows: The child is admitted for a three-day period of hospitalization. During this time he receives a complete physical examination, laboratory tests including skull X-rays and electroencephalogram. A blood test for syphilis and a urine test for phenylketonuria are done prior to admission by the local health department.

During the hospital stay he also receives hearing and vision testing, psychometric and other specialized examinations as requested by the pediatrician in charge. A social work history is taken and a "play" nurse contributes her observations of the child's behavior.

The results of all tests and observations are compiled and a clinical conference is held on the last day of hospitalization, at which time the team members endeavor to reach a decision as to the cause and extent of the child's handicap. The parents are then informed of this decision and are helped to determine a course for the child's future training.

It is interesting to note that institutional care has been recommended for only five of the thirty-six children, foster home care for another. The remainder were considered to be able to benefit from home training and, in some instances, special classes where available.

Following discharge from the center a special effort is made to enlist all of the resources available at the community level to assist the child and his parents—the public health nurse, the child welfare case worker, organized parents' groups, mental health clinics and others. Of course, children who have been referred by their own physicians are returned to his care with the clinician's recommendations for follow-up.

The great need for this service has been attested to by the agencies and individuals who have referred cases for evaluation. The majority (8) have come from the Commission for Handicapped Children; the second largest group (7) has been referred by the local health departments; four from child welfare case

(Continued on Page 530)

**Article was prepared by Helen B. Fraser, M.D., M.P.H., Director, Bureau of Maternal & Child Health, Kentucky State Department of Health, Frankfort, Kentucky*



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Public Health Page

(Continued from Page 526)

workers; four from private physicians; three from the Kentucky Society for Crippled Children and one was a parent referral. Cases have come from 23 counties of Kentucky.

The demand for this service has been so great that there are now 20 patients on the waiting list! A second clinic would appear to be indicated. The extensiveness of the work-up and observation rules out the possibility of admitting patients more rapidly or in greater numbers.

We are proud of the services of the Diagnostic and Evaluation Center and wish to convey our gratitude to Dr. Martin Z. Kaplan, the pediatrician who serves as clinician; to Mr. Frederick Veeder, the hospital's administrator, and others of his staff who have helped to make it a success.

News Items

E. F. Crocker, M.D., Fulton, has announced that he will start a five-year residency in plastic surgery at the Baptist Hospital, Nashville, Tenn., on July 1. He has sold his interest in Hillview Hospital to his partner, **John Ragsdale, M.D.** A graduate of the University of Tennessee Medical School, Doctor Crocker has practiced in Fulton since 1952. He and the late **Jack Blankenship, M.D.,** built the Hillview Hospital.

Samuel P. Gillis, M.D., has started practice in Middlesboro in association with Miners Memorial Hospital. A native of Knoxville, Tenn., he was graduated from the University of Tennessee Medical School in 1959 and interned at Holston Valley Community Hospital, Kingsport, Tenn.

David S. Colvin, M.D., has started practice in Radcliff after serving three years in the U. S. Navy, retiring with the rank of Lieutenant (MC) USNR. A native of Ingleside, he was graduated from the University of Louisville School of Medicine in 1956 and interned at Mercy Hospital, Springfield, Ohio. Doctor Colvin was health officer for Hardin and Meade Counties for 10 months in 1957-58.

Three Springfield physicians—**Marcus A. Coyle, M.D., Richard A. Hamilton, M.D.,** and **Dixie E. Snider, M.D.**—made up a panel for a joint program of the Springfield and St. Dominic Parent-Teacher Associations recently. The medical team answered questions submitted by members of the associations.

Roy G. Cooksey, Jr., M.D., has opened an office in his native Bowling Green for the practice of general surgery. A 1953 graduate of the University of Louisville School of Medicine, Doctor Cooksey served his internship and a 4½-year residency in general surgery at the Cook County Hospital, Chicago. He was a flight surgeon in the U. S. Air Force from 1955 to 1957, with the rank of captain.

Jorge Deju, M.D., has been appointed by the Hancock County board of health to be health officer for Hancock. Doctor Deju, a graduate of the University of Havana Medical School, will serve Hancock, Breckinridge, Meade and Grayson Counties.

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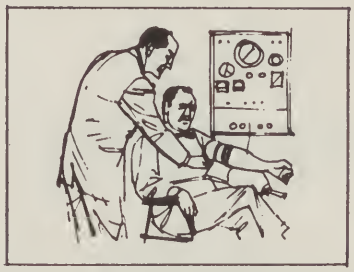
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references: (1) Lish, P. M.; Albert, J. R.; Peters, E. L., and Allen, L. E.: Arch. internat. pharmacodyn. *129*:77-107 (Dec.) 1960. (2)Howell, C. M., Jr.: North Carolina M. J. *21*:194-195 (May) 1960. (3) Clinical Research Division, Mead Johnson & Company. (4) Wahner, H. W., and Peters, G. A.: Proc. Staff Meet. Mayo Clin. *35*:161-169 (March 30) 1960. (5) Crepea, S. B.: J. Allergy *31*:283-285 (May-June) 1960. (6) Crawford, L. V., and Grogan, F. T.: J. Tennessee M. A. *53*:307-310 (July) 1960. (7) Spoto, A. P., Jr., and Sieker, H. O.: Ann. Allergy *18*:761-764 (July) 1960. (8) Arbesman, C. E., and Ehrenreich, R.: New York J. Med. *61*:219-229 (Jan. 15) 1961.

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(1) Buck, R. C.: Minerals of Normal and Arteriosclerotic Aortas, Arch. Path., 51, 1951. (2) N. Ressler, et al.: Relation of Serum Stability to the Development of Arteriosclerosis, Amer. J. Clin. Path. vol. 24, 1954. (3) S. D. Jacobson, M.D., Wayne County General Hospital, Eloise, Michigan. To be published. (4) Prof. V. Patzelt, Untersuchungen uber die Veranderunger der Bluteiweisz-Korper mit Mag. 3, 7-dimethyl-xanthine oleate, Klin. Med. 5, 11, 1956. (5) Dr. J. Skursky, Wiener Med. Wochenschrift, 1953, Nr 46, S. 886-887. (6) Eduard Keeser, M.D. and K. F. Benitz, M. D., Med. Klin. 1953 Nr. 15.



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MESSAGE FROM THE PRESIDENT

THE baseball season is here and before too very long the football season will be along with basketball to follow. All of these are bodily contact sports and are part of the growing-up of most American boys. Being contact sports, injuries naturally follow. These seem to be in proportion to the organization of the sport. With this organization, whether it be school, church, or Little League, there is an increase on the part of players, coaches and fans in the desire to win. The game simply for the fun of playing, gives way to rigorous practice and training culminating in a supreme effort in the games against similarly trained teams.

The boys who take part in these sports are in the high school or junior high school group, with efforts even being made to bring organized team sports to younger aged groups to supply better players to the older groups. All of them are in a period of growth and, in many, their muscular and bony development has not stabilized and they are subject not only to the acute injuries of the game but also develop symptoms of chronic strain.

I feel that it is the responsibility of the medical profession of the state to supervise these activities so that injuries may be prevented and those which do occur may be given adequate first aid at the time they happen. At present many of these are handled by coaches and trainers who may well be able to brace an injured ankle or knee so that the boy can go back into the game, but lack the judgment to know whether he should play or not. The ideal for which we can strive is a "team physician" for each organized team, certainly for each high school group. He should examine the players at the beginning of the season and should know their physical and emotional strengths and weaknesses. He should be interested in athletic injuries and familiar with those usual in each sport and their proper management. Above all he must be a man of character who will place the welfare of the boy before the appeals of coaches, parents, alumni and the player himself rather than have him play when he is not in condition to do so. This is the ideal. The least that we can do is to see that there is a competent physician present at each game ready to give proper emergency treatment.

Contact sports are part of American life. Whether they lead to optimum bodily development or chronic disability which will trouble the player the rest of his life depends on prevenative care and proper treatment. This should be the function of the medical profession rather than of laymen and it is the responsibility of each county society to see that the best care is given the players in their own communities.

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SPECIAL PROBLEM: SEVERE CARDIAC DISEASE

Elderly patients with pulmonary emphysema due to impending heart failure who required corticosteroid therapy showed that triamcinolone could be employed with benefit and relative safety. (McGavack, T. H.; Kao, K. Y. T.; Leake, D. A.; Bauer, H. G., and Berger, H. E.: *Am. J. M. Sc.* 236:720 [Dec.] 1958.)

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THE INSURANCE PAGE



Should Physicians List Their Fees on the Blue Shield Claim Forms?

IN each of its last two annual reports to the House of Delegates of the Kentucky State Medical Association, the K.S.M.A. Advisory Commission to Blue Shield has urged that every Kentucky physician, when completing a Blue Shield claim form, list his charges to the patient for the services rendered. This recommendation of the Advisory Commission was approved by the House of Delegates both times it was presented.

Several members of the Kentucky State Medical Association have opposed the listing of fees on Blue Shield and on insurance claim forms, and as their reasons for such opposition have offered the following opinions:

1. They do not feel that any useful purpose would be served by listing their fees, since Blue Shield operates on an indemnity basis in our state.
2. They believe that the listing of their charges to patients would tend to standardize fees—without individualizing the services rendered.
3. They fear that such a listing of fees might be used in the establishment of a relative value scale, to which they are opposed.

We have every respect for the sincerity of these individuals and for their right to believe as they do. It would be a unique experience if any subject could be found on which all members of our Association are in complete agreement.

As a member of the Advisory Commission to Blue Shield, as one who is convinced that the success of our voluntary prepayment mechanisms is our best method for preventing governmental control of medical practice, and as one believes that our own Blue Shield plan should continue to be increasingly effective in helping our people prepay for the costs of medical care, the editor of this Insurance Page wishes to request that each reader give open minded consideration to the reasoning which led the Advisory Commission to make its recommendation.

First of all we believe that the listing of fees on the Blue Shield claim form can, and does, serve a very useful purpose. In the last report of the Advisory Commission, it was mentioned that the Commission had requested the Board of Directors of Kentucky Physicians Mutual to undertake a study and re-evaluation of the schedule of indemnities. The members of the Advisory Commission were unanimous in feeling that such a re-evaluation was needed; since for some services, the current Blue Shield indemnities cover a fairly substantial proportion of the fees being charged, while in other instances, the indemnities which are allowed represent a much smaller fraction of the customary fees. This discrepancy has at times caused dissatisfaction on the part of physicians and subscribers alike.

It seemed to us that in trying to adjust these inequities, the best yardstick to employ would be a fund of statistical data on the actual fees which are being charged by our Kentucky physicians, rather than to be guided by fee schedules taken from other Blue Shield plans, or from commercial insurance companies.

Another reason that the House of Delegates approved the matter of listing regular fees on Blue Shield claim forms was to avoid unnecessary payment of claims when the fee for services rendered is less than the allowance for a given procedure.

It should also be recognized that in addition to the standard contract of our Kentucky Blue Shield Plan (which offers indemnities that are substantially below the usual fees for many procedures listed), there is now available a preferred contract with a more realistic schedule of benefits. In many instances the indemnities offered by the preferred schedule equal or approximate the fees usually charged for such

services by the majority of physicians. Experience has shown that the preferred schedule has been well liked by those subscribers who are covered by it, and by the physicians who render the services.

If the present inflationary trends in our economy continue, it is probable that in time there may have to be a gradual upgrading of some of our medical and surgical fees in order to keep pace with our rising overhead costs.

If the coverage offered by the preferred Blue Shield schedule is to remain realistic and adequate, it will be important that this trend be recognized. The best way in which this can be accomplished, will be to have available a well documented file of the fees currently being charged by our physicians.

The fear that the use of prepayment mechanisms may result in some tendency toward standardization of fees is as old as is the use of such mechanisms. The fear is not entirely unfounded. Frankly, any schedule of benefits, or of payments towards physicians fees, places a monetary value on the services rendered in the reasoning of the subscriber. This is true whether the indemnity be adequate or inadequate; and whether it be paid by Blue Shield or by private insurance companies.

There are, we hope, no physicians in practice today, who would favor abandonment of the voluntary prepayment principle because of fear that this approach toward solving the economic problems of medical care could result in some loss of freedom to charge as one sees fit.

If such there are, we suggest that they read the article "The Facts of Life in the Future of American Medicine" in the January issue of our State Medical Journal. In this article, Dr. John B. Reckless, a physician who worked for many years under the British National Health Service, stated that he considered our prepayment medical plans our best and most effective challenge to government sponsored health insurance.

Granted that prepayment benefit schedules may tend to produce some degree of uniformity of fees; to what extent will the listing of physicians' fees on Blue Shield claim forms increase this tendency?

In our opinion, not at all. The only effect which could result from the accumulation of this mass of data, would be to enable the plan to develop a better and fairer schedule of benefits than it now has.

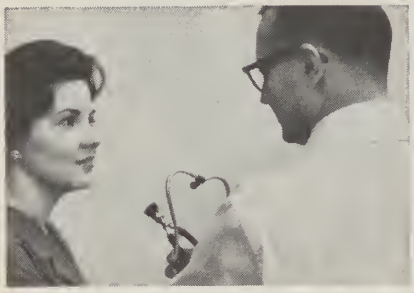
The third objection which has been voiced is the fear that a listing of fees might be used in the establishment of a relative value schedule.

As a matter of record, there are many of us who happen to believe that the advantages of having a relative value schedule to use as a yardstick in appraising the relative worth of one procedure as compared to another, far outweigh the disadvantages of such a schedule. We realize, however, that the majority of the members of the KSMA do not seem to share our viewpoint on this subject.

The request that physicians list their fees on Blue Shield claim forms, however, is *not* an attempt to institute a relative value study. No effort is being made, for example, to correlate the charges for performing an appendectomy with those for delivering a baby or setting a fracture—at least, to any greater degree than already exists under our present schedule of indemnities, or under any other fixed fee schedules. The objective of the recommendations for listing fees, as already stated, is to discover for each procedure covered, the relationship between the fees being charged and the indemnities which are allowed, for that particular procedure.

To summarize our position: we believe that Kentucky Physicians Mutual, Inc., can develop a more realistic and efficient program of prepayment, and can more readily adjust its schedule of indemnities from time to time, to meet changing conditions, if physicians' fees can be predicted with reasonable accuracy; than will be possible if such fees remain a mystic secret, to be divulged only to the patient and to God.

We fail to see any way in which a fair and realistic schedule of indemnities, based on a knowledge of the fees actually charged will be more restrictive to physicians than a schedule of indemnities borrowed from other plans, or predicated on guesswork.



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*Gamble, C.J.: Am. Pract. & Digest. Treat. *11*:852 (Oct.) 1960. See also Berberian, D.A., and Slighter, R.G.: J.A.M.A. *168*:2257 (Dec. 27) 1958; Kaufman, S.A.: Obst. and Gynec. *15*:401 (March) 1960; Warner, M.P.: J.Am.M. Women's A. *14*:412 (May) 1959.

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1. Youmans, J. B.: Am. J. Med. 25:659 (Nov.) 1958

cardiac diseases "Who can say, for example, whether the patient chronically ill with myocardial failure may not have a poorer myocardium because of a moderate deficiency in the vitamin B-complex? Something is known of the relationship of vitamin C to the intercellular ground substance and repair of tissues. One may speculate upon the effects of a deficiency of this vitamin, short of scurvy, upon the tissues in chronic disease."[2] 2. Kampmeier, R. H.: Am. J. Med. 25:662 (Nov.) 1958.

arthritis "It is our practice to prescribe a multiple vitamin preparation to patients with rheumatoid arthritis simply to insure nutritional adequacy . . ."[3]
3. Fernandez-Herlihy, L: Lahey Clinic Bull. 11:12 (July-Sept.) 1958.

digestive diseases Symptoms attributable to B-vitamin deficiency are commonly observed in patients on peptic ulcer diets.[4] Daily administration of therapeutic vitamins to patients with hepatitis and cirrhosis is recommended by the National Research Council.[5] 4. Sebrell, W. H.: Am. J. Med. 25:673 (Nov.) 1958. 5. Pollack, H., and Halpern, S. L.: Therapeutic Nutrition, National Academy of Sciences and National Research Council, Washington, D. C., 1952, p. 57.

degenerative diseases "Studies by Wexberg, Jolliffe and others have indicated that many of the symptoms attributed in the past to senility or to cerebral arteriosclerosis seem to respond with remarkable speed to the administration of vitamins, particularly niacin and ascorbic acid. These facts indicate that the vitamin reserve of aging persons is lowered, even to the danger point, more than is the case in the average American adult."[6] 6. Overholser, W., and Fong, T.C.C. In Stieglitz, E. J.: Geriatric Medicine, 3rd edition, J. B. Lippincott, Philadelphia, 1954, p. 264.

infectious diseases Infections cause a lowering of ascorbic acid levels in the plasma; and the absorption of this vitamin is reduced in diarrheal states.[7] 7. Goldsmith, G A.: Conference on Vitamin C. The New York Academy of Sciences, New York City, Oct. 7 and 8, 1960. Reported In: Medical Science 8:772 (Dec.10) 1960.

diabetes Diabetics, like all patients on restricted diets, require an extra source of vitamins.[8] "Rigidly limiting the bread intake of the diabetic patient automatically eliminates a large amount of thiamin from the diet. . . .There is some evidence of interference with normal riboflavin utilization during catabolic episodes."[9]
8. Duncan G. G.: Diseases of Metabolism 4th edition W. B. Saunders, Philadelphia, 1959, p. 812. 9. Pollack, H.: Am. J. Med. 25:708 (Nov.) 1958.

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References: 1. Lineback, M.: The Eye, Ear, Nose and Throat Monthly *39*:342 (April) 1960. 2. Fuchs, A. M. and Maurer, M. L.: New York J. Med. *59*:3060 (August 15) 1959. 3. Kreindler, L. *et al.:* Antibiotic Med. and Clin. Therapy *6*:28 (January) 1959. 4. Schiller, I. W. and Lowell, F. C.: New England J. Med. *261*:478 (September 3) 1959. 5. Edmonds, J. T.: The Laryngoscope *69*:1213 (September) 1959. 6. Horstman, H. A.: Am. Pract. & Digest Treat. *10*:96 (January) 1959.

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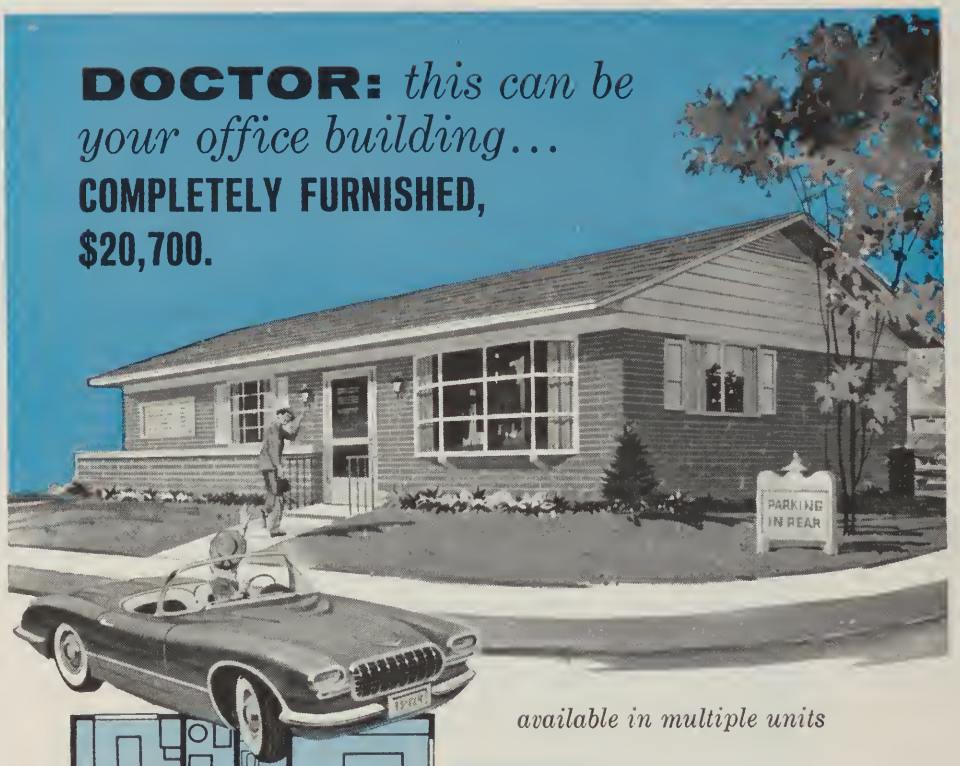
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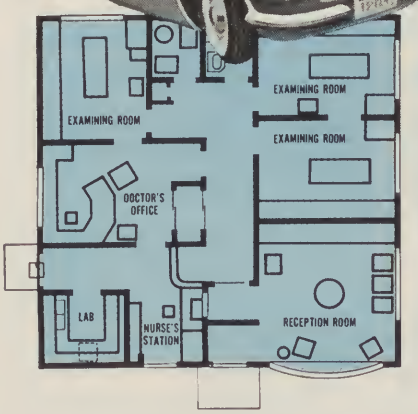
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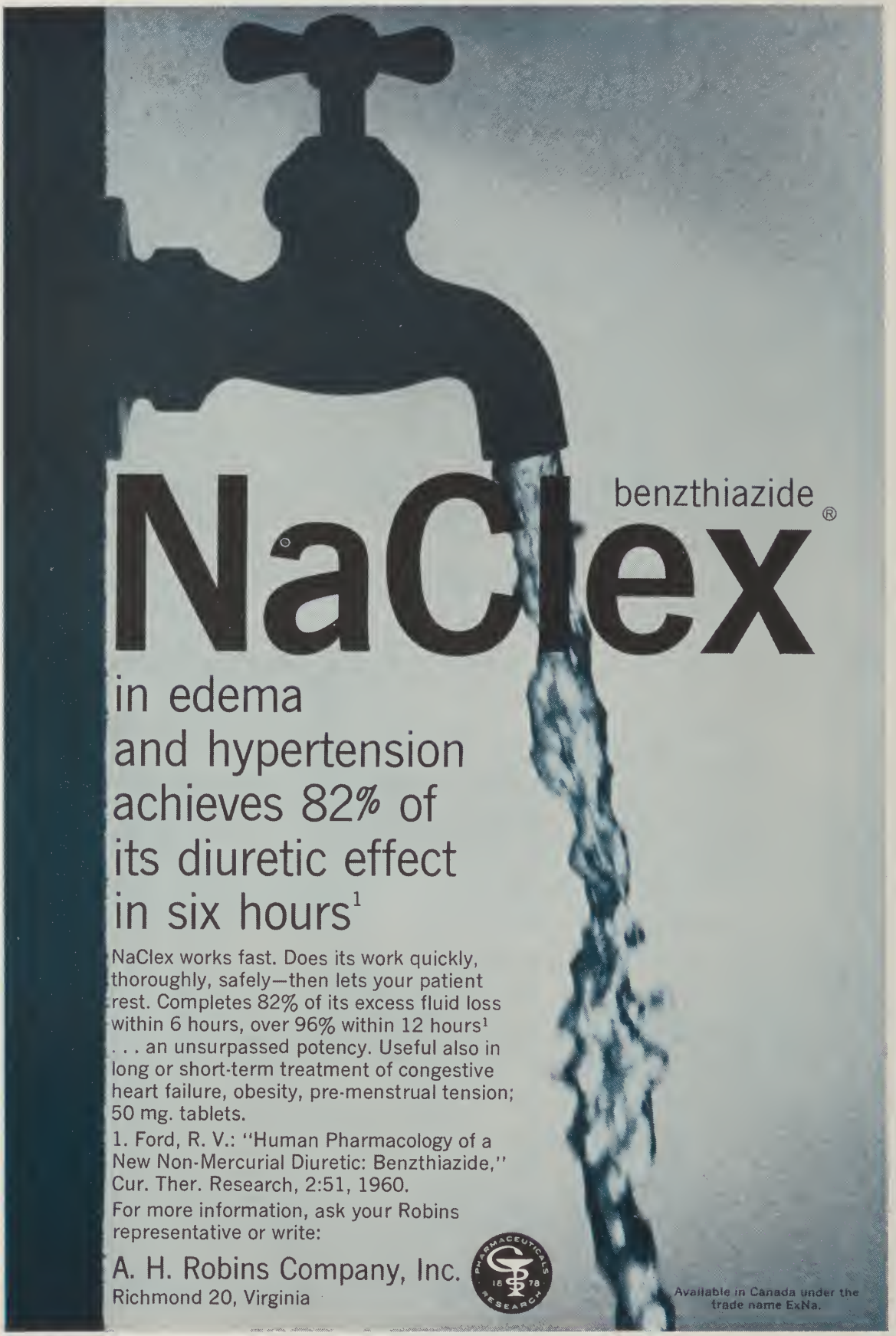
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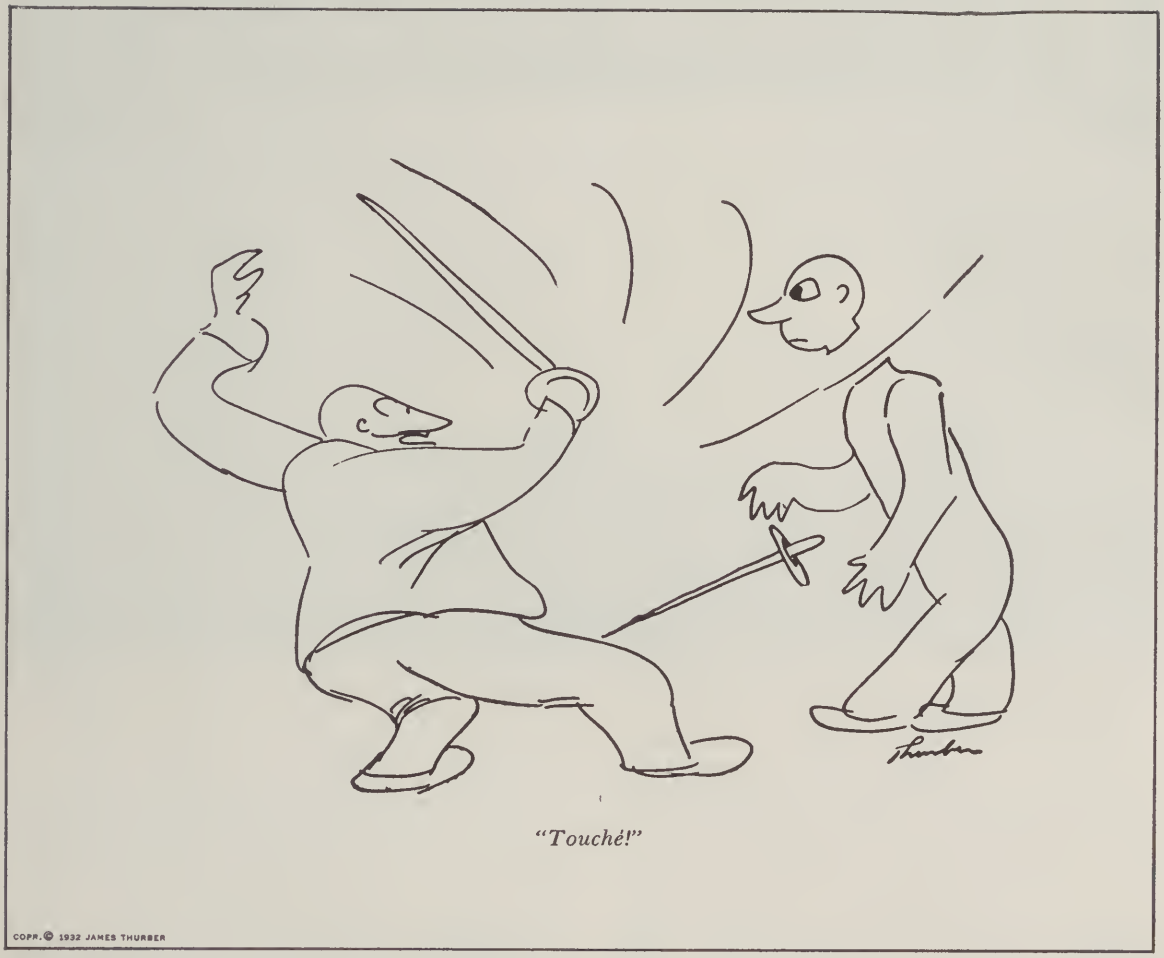
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1. Ford, R. V.: "Human Pharmacology of a New Non-Mercurial Diuretic: Benzthiazide," Cur. Ther. Research, 2:51, 1960.
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WASHINGTON NEWS DIGEST



Washington, D. C.—The American Medical Association branded as untrue certain statements by Abraham Ribicoff, Secretary of Health, Education and Welfare, concerning the Administration's legislative proposal to provide medical care for the aged under Social Security.

F. J. L. Blasingame, M.D., A. M. A. executive vice president, presented a point-by-point rebuttal in a letter to the more than 500 editors from throughout the country after Ribicoff addressed the annual meeting of the American Society of Newspaper Editors in Washington.

Edward R. Annis, M.D., Miami surgeon representing the A. M. A., accused Ribicoff of misrepresenting the role of doctors under the administration proposal. Doctor Annis answered Ribicoff on a radio-television program with Sen. Kenneth B. Keating (R.,N.Y.) which was taped in Washington. Ribicoff had made the misrepresentation on an earlier Keating program.

Doctor Blasingame said Ribicoff's statement before the editors that physicians are not included in the administration proposal, the King bill, "simply is not true." The A. M. A. official pointed out that the bill includes interns and residents in teaching hospitals as well as pathologists, radiologists, psychiatrists and anesthesiologists working in hospitals or serving hospitals' outpatient clinics.

"Mr. Ribicoff further claims that the King bill provides free choice of hospital physician," Doctor Blasingame said. "The fact is only hospitals signing contracts with the federal government would be available to patients. If the only hospital in a community was not approved by the Secretary of HEW, patients in that community would be forced to seek hospitalization in some other city. That would not afford free choice of hospital. If the patient's physician was not on the staff of the other hospital, the patient would be denied free choice of physician."

Doctor Blasingame also disputed Ribicoff's contention that the King bill is not socialized medicine.

Rep. Walter H. Judd (R., Minn.), who is a physician, was quoted as one of a number of House and Senate members who agree with the A. M. A.: "The public has been led to believe that they can get government financing without government control and ultimate government operation of medical services. It is naive for anyone to believe that Congress will take the people's money away from them through taxes and then allow the money to be spent by someone else without the Congress maintaining its own firm control."

Pointing out that the nation's physicians always have been in favor of medical care for all regardless of ability to pay, Doctor Blasingame said:

"It seems strange to us that Mr. Ribicoff continues to lobby for the King bill while completely ignoring the Kerr-Mills law, passed by Congress last year with strong support by the nation's physicians.

"The Kerr-Mills Law enables the states to guarantee to every aged American who needs help the health care he requires. And the states are implementing the law with unprecedented swiftness."

Doctor Annis pointed out on the radio-television program that "doctors would work for the government by working for the hospitals under contract to the government." He said those doctors would work "under rules, regulations and controls prescribed and laid down" by the HEW.

KREBIOZEN EVALUATION—The Department of Health, Education and Welfare has agreed to make an impartial evaluation of the controversial cancer drug Krebiozen.

U. S. District Judge Julius H. Miner of Chicago requested the evaluation before proceeding with a $300,000 libel suit filed by Andrew C. Ivy, M.D., a leading endorser of the drug, against George D. Stoddard, Ph.D., chancellor of New York University of Illinois.

In a letter to HEW Secretary Ribicoff, Miner said:

"In my humble judgment, Krebiozen has too long been a controversial subject and the American public deserves that it be examined under neutral supervision and by the most competent experts in whom the people have implicit confidence."

Ribicoff said the National Cancer Institute would evaluate the drug when its sponsors presented the necessary data. But, he said, "any decision to undertake a study with human cancer patients must await, and depend on, the results of the evaluation of the existing clinical data."

PHYSICIANS' RETIREMENT—A new bill to encourage physicians and other self-employed persons to set up their own retirement plans started through Congress with approval of the House Ways and Means Committee.

Bearing the same number, H.R. 10, as a similar bill which died in Congress last year, the new measure would permit a self-employed person to defer taxes on income placed in a private retirement program. The special treatment would be limited to $2,500 or 10 per cent of income each year, whichever is smaller.

Such income could be invested in qualified pension trust, annuity programs, profit-sharing plans or a new type of non-transferable government bonds redeemable when the individual reaches retirement age or suffers disability.

An individual could start drawing benefits at age 59½, or earlier in the case of disability. A self-employed person would have to start drawing benefits by age 70½.



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Saturday, July 29, 1961
The Aldridge Hotel

SEATTLE, WASHINGTON
Saturday, August 5, 1961
The Olympic Hotel

KANSAS CITY, KANSAS
Friday, September 15, 1961
Battenfeld Memorial Auditorium

TOLEDO, OHIO
Thursday, September 28, 1961
The Commodore Perry Hotel

WICHITA, KANSAS
Wednesday, October 4, 1961
The Broadview Hotel

TRAVERSE CITY, MICHIGAN
Friday, October 13, 1961
The Park Place Hotel

PEORIA, ILLINOIS
Thursday, October 26, 1961
The Hotel Pere Marquette

PROVIDENCE, RHODE ISLAND
Wednesday, November 1, 1961
The Colony Motor Hotel

HARRISBURG, PENNSYLVANIA
Thursday, November 9, 1961
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JACKSONVILLE, FLORIDA
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References: 1. Smigel, J. O., *et al.:* J. Am. Geriatrics Soc. *7*:61 (Jan.) 1959. 2. Shalowitz, M.: Geriatrics *11*:312 (July) 1956.

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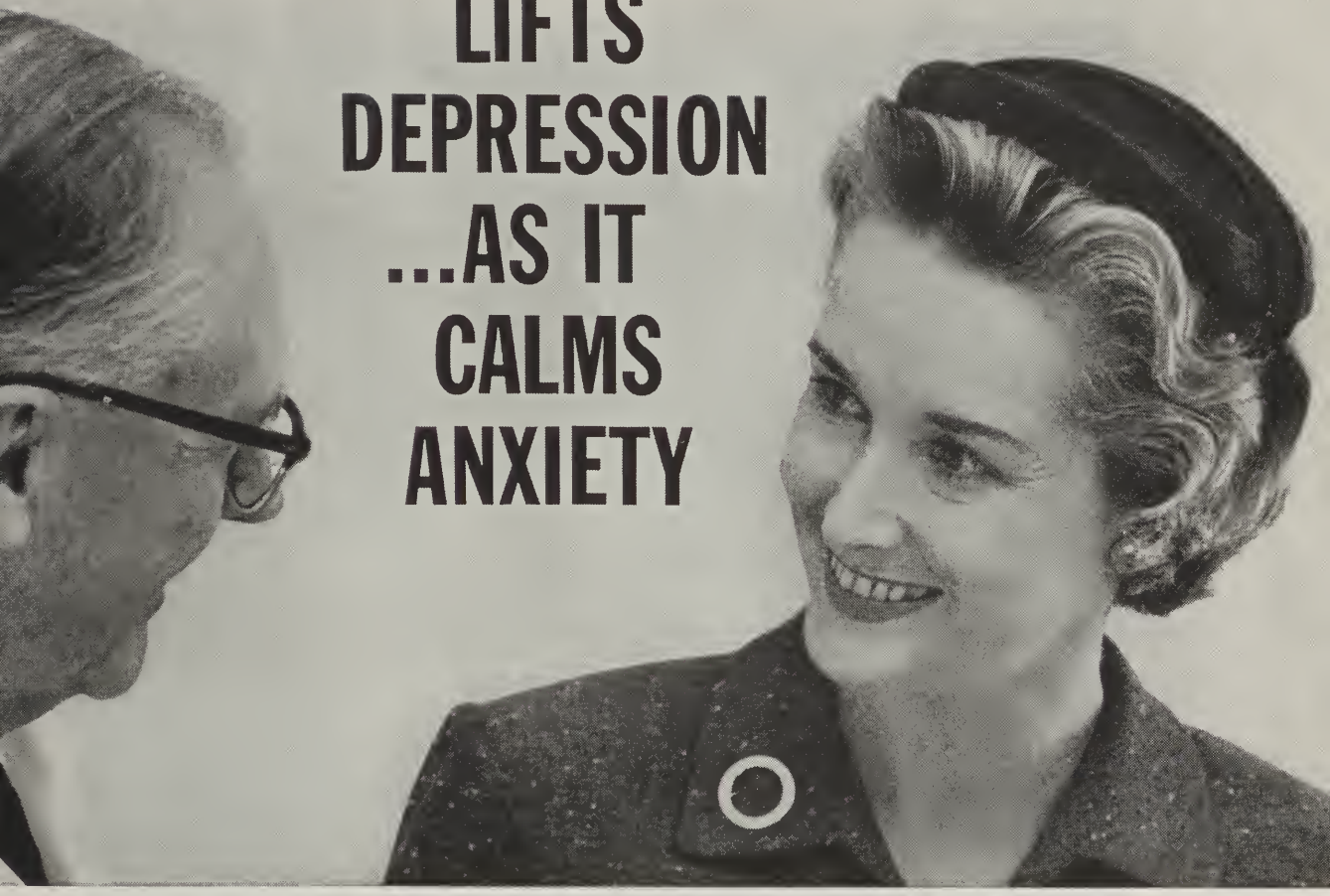
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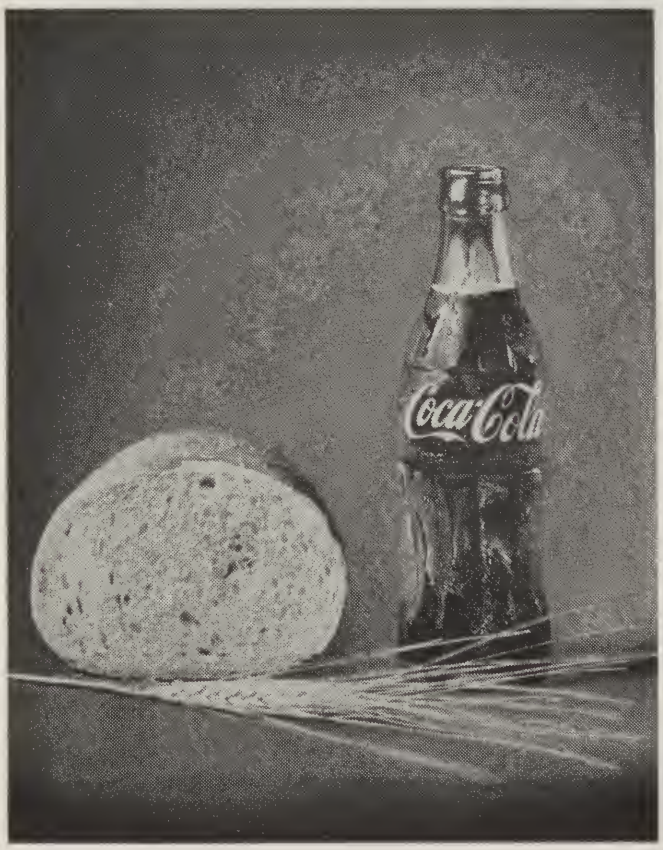
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VOL. 59 JUNE, 1961 NO. 6

Pulmonary Embolism

PORTER MAYO, M.D.

Lexington, Ky.

This pulmonary disease, always one of the most serious in hospital practice, now occurs with such frequency that it challenges both pneumonia and bronchogenic carcinoma statistically.

PULMONARY emboli are frequently the first, and often the last, expressions of phlebothrombosis. Although death at times may be charitable, this sudden catastrophe is inconceivably harsh. Though the exact mechanism of death is not known, several contributing factors are recognized, namely, (1) hemoconcentration, (2) changes in the coagulation mechanism, (3) stasis from bed rest and infrequent change of position, and (4) deleterious action of humoral agents. This unsavory league is further complemented by a factor of ever increasing proportions, specifically, that of an aging hospital population.

Definitions

Pulmonary embolism and pulmonary infarction are not synonymous terms. A pulmonary embolus is a foreign body, usually a portion of a thrombus, which has lodged in a branch of a pulmonary artery with or without changes in the lung tissue supplied by that branch. The term infarction is applicable when the obstruction produces a profound change in the lung progressing to necrosis. The pulmonary artery receives blood from the caval system of veins and acts as a carrier to the lungs. It is easily blocked by adventuresome emboli arising in the systemic venous system and is particularly vulnerable as it is an end artery with no collateral circulation.

When the main divisions of the pulmonary artery are obstructed by emboli, interference with lung function is so great that death occurs within a few minutes. If, however, only minor arterial branches are blocked, only small areas of the lungs lose their function and the patient survives; however, this area becomes an avascular segment and is properly designated as an infarct. Due to the use of antibiotics it is now infrequent to observe abscess formation resulting from the occurrence of infarcts.

Pathologic Physiology

It is believed that the acute reaction of pulmonary embolism is due in part to spasm of the artery. The occurrence of acute cor pulmonale following pulmonary embolism is the consequence of generalized reflex contraction of the pulmonary vascular bed. A reflex response to embolization has been attributed both to local and to sympathetic reflexes. There is some evidence that the reflex response to embolization varies with the size of the vessels blocked. Brofman et al. have reported a reflex response to blockage of small pulmonary arteries that is not obtained by blockage of the main pulmonary arteries.[1]

A rise in the pulmonary artery pressure is attributable to pulmonary embolism; however, there are divergent opinions on whether or not this rise in pressure is produced only by a reduction in the size of the pulmonary vascular bed or by the emboli or whether or not reflex vasoconstriction occurs in addition. Treatment is directly related to this important problem. Although completely effective therapy is not available, large doses of atropine sulfate intravenously as well as antispasmodic substances, including papaverine, aminophylline and opium derivatives, have been advocated. Oxygen therapy by inhalation is likewise of value.

Emboli may be found in elastic arteries only, they may co-exist with embolism of muscular arteries or embolism may be restricted to the small vessels. Emboli are more easily recognized when large, not only because of their size, but because their source is easier to find. It has also been suggested that blood pressure can compress large emboli into small vessels, for red thrombi are soft, or that emboli become fragmented by striking bifurcations. There is even evidence that small emboli do not necessarily arise from some mural source and that they arise within flowing venous blood. Small emboli need not cause permanent obstruction for they may disappear without trace, presumably by fibrinolysis.

Obstructive Effects Lessened

The lungs have an enormous capacity for disposing of blood clot, and this may well be an essential, if unrecognized, pulmonary function. The obstructive effects of thromboemboli may also be lessened by flattening against the intima by blood pressure by canalization, and by shrinking during the process of organization.[2] Although an embolism may not at the time attract n o t i c e, it may, by additional thrombosis, precipitate cor pulmonale long after arrest in the lung has occurred. This is due to clotting of the motionless column of blood between the embolus and the next arterial branch, a process which may extend not only outward into smaller vessels but also toward the heart.

Apart from the 'red' thrombosis, obstruction to pulmonary blood flow can increase because the embolus enlarges by successive stratified deposits of fibrin and platelets, or 'white' thrombosis.[3] Repeated lodging of silent emboli in the lungs over months and years may, by the development of endarteritis obliterans and other organic arterial changes, reinforce embolic plugging. Demonstrations in both man and in animals attest to the arteriosclerotic action of blood clots on pulmonary arteries, an action which is exerted both at and away from sites in which the clots are found.

Physical Diagnosis

The diagnosis of pulmonary embolism is often difficult. The presence of hemoptysis and pleural friction rub is usually considered indispensable to the diagnosis; however, it is not uncommon to establish a diagnosis without one or both of these manifestations. Other nonspecific symptoms such as fever, dyspnea, pleuritic chest pain, pulmonary rales, tachypnea and tachycardia, are also important.

One of the most compelling symptoms is pain. In pulmonary embolism, pain of two types is experienced. The first type is produced by reaction of the pleura overlying the infarction and the second is that of anterior chest pain which is severe and often indistinguishable from that of myocardial anoxia. Splinting and difficulty in breathing are often the result of such discomfort. It is the belief of some workers that pain is the result of an actual diminution in the coronary flow secondary to the profound disturbances in local hemodynamics. It is believed by others that this pain is due to localized changes in the pulmonary artery itself.

Dyspnea, which is a common manifestation of pulmonary embolism, is due to splinting caused by the pain. Cough and hemoptysis are very important corroborative signs and if absent, the diagnosis is difficult to confirm. However, some patients with convincing evidence of pulmonary embolism do not have hemoptysis. Panic and fear of impending disaster are frequently observed in these patients and are sufficiently common to warrant the immediate attention of the attending physician.

Whether or not the patient experiences fever depends upon the degree of infarction or secondary pneumonitis and the presence or absence of phlebitis at the site of origin. The degree of temperature elevation is variable. A marked fever may be present. When tachycardia is

present, the change in heart rate is usually proportional to the fever. In rheumatic heart disease, an arrhythmia is often responsible for many emboli.

Any patient becomes a candidate for pulmonary emboli if fibrillating. Even patients with normal rhythm may at times experience an episode of paroxysmal fibrillation, discharge an embolus and then revert to normal rhythm in a period of several hours. It is believed that the recently formed thrombus or recently propagated new clot superimposed upon the old clot is responsible for the embolization.

Bronchial breathing and pleural friction rub are often present as well as dullness to percussion and other evidence of consolidation if the infarct is large enough. Directly over the areas of effusion decreased breath and voice sounds will be heard. An increase in effusion, of course, is denoted by flatness. The presence of rales somewhere in the chest is a most important finding to support the diagnosis.

Other Findings

Laboratory: Leukocytosis with an increase in polymorphonuclear leukocytes is usually present, depending on the presence or absence of phlebitis and pneumonitis. The sedimentation rate increases rapidly during the first week.

Studies of serum glutamic oxalacetic transaminase (SGO-T) levels following pulmonary embolism have indicated that significant elevations did not occur after uncomplicated pulmonary embolism. Further experience has confirmed the value of SGO-T determinations in the differential diagnosis of myocardial infarction and pulmonary embolism. The determination of SGO-T levels in such patients is important because a normal value 24 to 48 hours after the onset of pain excludes myocardial infarction more speedily than do other tests.[5]

X-ray: The presence of a shadow in the lung fields will be found only if some degree of infarction has occurred. The shape, size and density of the shadow depend on the angle which the infarct makes to the direction of the X-rays. Thus, shadows vary from small, hazy, mottled areas to large dense segments. The classic pie-shaped area, while sometimes seen, is not found in the majority of cases. Some degree of pleural effusion is usually seen in the X-ray films sometime during the course of the illness.

Electrocardiographic: A large pulmonary embolus, by blocking a generous percentage of pulmonary artery flow, produces an increase in pulmonary artery pressure. This in turn is reflected in the heart by dilation of the right ventricle and what is termed "right heart strain." The electrical changes are a shift of the axis to the right with clockwise rotation.[4]

A meticulous study of the whole patient is paramount if one is to make a diagnosis of pulmonary embolism. Frequently the individual appears considerably more apprehensive than the objective signs justify. It has frequently been noted that examination of the legs may prove to be more informative than examination of the chest. Signs of thrombosis in the legs should be emphasized as a finding which may not be definite until several days after the occurrence of pulmonary embolism. Fifty per cent of emboli occur without signs in the legs.

Pulmonary embolism has been likened to lightning due to the suddenness with which it strikes. If the patient survives the initial shock, he has a rather good chance of surviving that particular embolus; however, emboli which are yet to be delivered, are most to be feared. Fatal pulmonary emboli are frequently preceded by small ones. About a third of the patients die with their first pulmonary infarct, and others with the second or third arterial obstruction.[6]

Early Ambulation

Early ambulation may be utilized as a prophylactic agent against venous thrombosis. It has not proved to be effective when ambulation has been interpreted to permit merely early sitting, a posture which tends to increase rather than diminish stasis in the leg veins. Wilkins and his associates have demonstrated a significant reduction in the incidence of thromboembolism in their hospital patients by routine employment of elastic stockings. Increase in linear velocity of blood flow in the legs, brought about by reducing the caliber of the veins by means of elastic stockings, is presumably responsible for reduction in venous thrombosis, and hence embolism. Once thrombosis develops, elastic bandages are of no value in preventing embolism.[7]

Treatment

Treatment of an infarct is directed toward (1) controlling the circulatory reaction to embolism, (2) relieving symptoms resulting from infarction, and (3) preventing further embolism. Infarction produces a pleuritic type pain which is often severe and difficult to relieve. Strapping is ineffective and inadvisable. Paravertebral procaine block or intercostal infiltration may be necessary for relief of pain. Demerol® and codeine may be utilized in doses which will not significantly depress respiration. Although it is rare to see a profuse hemorrhage, protracted periods of hemoptysis may occur. This does not contraindicate the use of anticoagulants. For the control of cough, one may use sedative type cough preparations as necessary.

Due to the possibility of infection and abscess formation, it is justifiable to administer antibiotics following infarcts. Recent studies have failed to support the contention that the administration of penicillin or other commonly used antibiotics produce an increased tendency to thrombosis. Further embolization is prevented by ligation or by employing anticoagulant therapy.

Surgical Ligation Less Popular

Recently, surgical ligation has become less popular due in part to the frequency with which edema results but more importantly because it too often fails to accomplish its purpose. Embolism may continue to occur either because the actual source of the emboli was not attacked e. g., ligation of femoral veins when pelvic phlebitis was responsible for embolism, or more often because of the tendency of thrombi to form proximal to the site of ligation.

Anlyan and his associates observed that five of seven patients treated with ligation had pulmonary emboli shortly thereafter. One of these died. These authors feel that a sense of security following ligation of superficial femoral veins is not justified.[8] Ligation of the inferior vena cava is the procedure of choice if anticoagulant therapy is contraindicated. Several adequately controlled large scale studies have demonstrated the effectiveness of anticoagulant therapy.

Cosgriff has presented the following data: Of 678 cases of nonfatal pulmonary embolism given symptomatic treatment, further emboli occurred in 30 per cent and fatal embolism in 18 per cent. In 817 cases treated by anticoagulants, 1.1 per cent had further emboli, and fatal embolism occurred in 0.9 per cent. In the Graduate Hospital study the 29 postoperative patients who had nonfatal embolism and were given anticoagulants had no further emboli and all survived. It is clear that anticoagulants do not dissolve formed thrombi but merely prevent additional thrombosis. Investigation now in progress is directed at lysis of partially organized clot by enzymatic means.[9]

The dangers of anticoagulant therapy have been decreased by the introduction of effective antagonists. Even so, such therapy is not without some hazard. Dicumarol®, though inexpensive, requires costly laboratory control. Heparin costs more but does not require expensive laboratory studies. During the past few years a variety of modifications and substitutes for heparin and Dicumarol have been introduced. However, the newer drugs have not achieved wide usage as they have not represented a substantial improvement.

In the presence of hepatic disease or renal insufficiency, neither heparin nor Dicumarol should be employed. They should be used only with great caution in patients with gastrointestinal ulceration. Following surgical operations they may be administered almost immediately except after procedures on the central nervous system. Fatal embolism may occur without warning; however, most instances of massive pulmonary embolism give forewarning by minor emboli or by signs of phlebitis.

Summary

In summary, pulmonary embolism must be accorded the most serious consideration in the differential diagnosis of every acute cardiorespiratory illness. It is indeed remarkable and disquieting that pulmonary embolism which has been so frequently demonstrated by the pathologist remains relatively seldom detected prior to autopsy. The aging hospital population beckons this killer and it is only by the prompt application of antiembolic measures, whenever thromboembolism is suspected, that effective means of averting tragic and unnecessary deaths from this disease may be realized.

(References on Page 625)

The Role Of Surgery In the Treatment Of Parkinson's Disease*

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Disabling features of Parkinson's disease, especially tremor and rigidity, may be abolished or ameliorated by a simple, safe operation in the region of the medial globus pallidus.

FOR more than 20 years neurosurgeons have attempted to relieve the disabling features of Parkinson's disease by an assortment of operative attacks on the central nervous system. The disabling features of the disorder, consisting classically of tremor, rigidity and gait disturbances, present a tempting lure to the neurological surgeon. The relief of tremor and rigidity would, at first glance, seem to represent a simple mechanical neurologic problem since the abolition of these handicaps might be accomplished by surgical destruction of certain areas of the cortex or portions of the pyramidal or extra pyramidal system that readily lend themselves to surgical exposure.

Review of Surgical Attacks

Excision of motor cortex and/or pre-motor cortex was practiced by Klemme[1], Bucy[2] and Pilcher[3], but in most instances hemiparesis was an invariable sequel to cortical excision and, in addition, many such patients became subject to convulsive seizures as a postoperative complication. Surgical interruption of other areas of the pyramidal system have similarly failed to produce good results with consistency or have proven to be procedures of surgical magnitude that could not be carried out with safety except upon the most suitable surgical candidates. Such has proven to be the case in the internal capsulotomy of Browder, extirpation of portions of the caudate nucleus (Meyers), section of the cerebral peduncle (Walker), and cervical cord pyramidal section (Putnam).

The region of the basal ganglia has generally been considered an area in which the surgeon can work only with great risk and resultant disability to the patient. It is through the pioneer work of Browder[4], Meyers[5], Fenelon[6], Bertrand[7], Guiot[8], Cooper[9], and Speigel and Wycis[10] that this area can now be approached by stereotactic methods and surgical lesions placed in the various nuclear masses of the area. Furthermore, opportunities for increasing our knowledge of the complex physiological functions of the basal ganglia are afforded by the use of stimulation and recording, as well as the study of the effects of lesions placed in the surgical target area.

Thus far, no therapeutic approach to Parkinson's disease, either medical or surgical, has proven to be curative. In fact, the precise nature of the altered physiological functions of the nervous system in this disorder remain a baffling enigma.

Presently Used Techniques

Our surgical attempts to lessen the disabilities of Parkinson's disease over the past six years have been directed towards the production of a discrete lesion in the area of the mesial globus pallidus which would effectively diminish or abolish tremor and lessen muscular rigidity

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contralateral to the lesion. This we were not able to accomplish consistently until the adoption of newer technics which currently appear promising.

Ligation of the anterior choroidal artery as described by Cooper has, in our hands, produced inconsistent results. It was abandoned when it became obvious that the variability of blood supply to the globus pallidus was too great to allow for a predictable ischemic lesion when the anterior choroidal artery was surgically occluded. Similarly, our feeling of insecurity concerning the size, extent and control of the necrotizing lesion produced by the repeated injections of absolute alcohol has led to our use of a small wire leucotome to produce a surgical lesion of known diameter in the chosen target area.

There is mounting evidence that in or about the region of the mesial globus pallidus there is a critical area where a destructive lesion may produce an immediate salutary result upon rigidity and tremor. The size of this critical area is not established, but discrete lesions in the magnitude of 10-12 mm diameter have thus far seemed sufficient. There is also evidence that to produce durable effects upon these disabling features one or more surgical lesions may be necessary. Anteriorly placed lesions are less likely to control tremor than lesions placed more posteriorly, although they may consistently relieve rigidity.

The Operative Procedure

The technique of the operative procedure is not formidable and is not considered an operative undertaking involving great risk. The entire procedure is performed under local anesthesia, since the cooperation of the alert patient is essential. A spinal puncture is first performed in the sitting position and a 40 cc fluid-air exchange is carried out. Initial Polaroid films in the anterior-posterior and lateral projections are then taken and the ventriculographic landmarks are identified and the appropriate coordinates determined.

A small scalp incision is made under local anesthesia and a burr opening made 14 cm. posterior to the nasion and 3 cm. from the midline. The pallidotomy guide is then fixed to the skull overlying the burr opening and through a small dural incision the leucotome is introduced into the cortex and maintained in the estimated appropriate position by the fixed pallidotomy guide until additional Polaroid films (which may be viewed in 60 seconds) have been made and the position and direction of the leucotome assessed. By projection of lines drawn directly on the film, corrections in the coronal and sagittal planes can be made and their correctness ascertained by a series of X-rays taken as the leucotome is inserted deeper through the hemisphere until the target area is encountered.

Frequently, the entrance of the leucotome into the globus pallidus is accompanied by a dramatic cessation of tremor or the appearance of hypotonia of the contralateral musculature and is often announced by the patient. The wire loop is then extruded and turned through a 360 degree angle, each quadrant being separately cut while observations are carried out for weakness, aphasia, finger dexterity and cessation of tremor and rigidity. A small amount of radio-opaque dye is then injected into the site of the surgical lesion as a long-lasting marker. The depth of the leucotome insertion is recorded along with readings from a coronal and sagittal vernier scale on the pallidotomy guide. These recordings have proven accurate and reliable in placing the instrument precisely into the initial area if a second or third lesion becomes necessary later.

Selection of Cases

In the authors' opinion, the selection of cases for pallidotomy consists of stringent observance of the usual criteria for elective surgical procedures. Age, per se, is not a contraindication, although clinical evidence of advanced senility should mitigate against selection. Furthermore, the presence of stigmata of Parkinson's disease alone is not a sufficient criterion for recommending pallidotomy. It is our feeling that not only must the patient be a satisfactory elective surgical risk, but that the disease must have produced a disability for work or self care that has not been ameliorated by a conscientious trial with established drug therapy The ideal candidate for pallidotomy is the otherwise healthy individual under the age of 55 with the disease predominantly confined to

one side and without violent resting tremor.

Since the disorder is so often seen as a bilateral disease it is our practice to separate the operative procedures by a period of several months, although on a few occasions the severely handicapped have had bilateral lesions performed within a two-to-three-week period and during a continuous period of hospitalization. Currently, it is our practice to advise each patient contemplating pallidotomy that he must accept the likelihood of having from one to three operative procedures performed in the attempt to attain a lasting beneficial effect upon his tremor and rigidity.

Fortunately, the production of pallidal lesions subsequent to the initial one assumes the role of a relatively minor surgical exercise, since the same cranial opening is employed. By utilizing the vernier readings in conjunction with the previously established site marker, the leucotome can be accurately and quickly introduced into the desired area.

Deaths and Complications

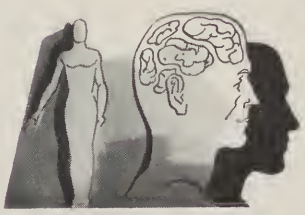
In the two years in which the present technique has been employed, in 60 patients there have been only two deaths, one occurring six months after surgery as the result of a surgically produced intracranial hemorrhage (the only major operative complication), and one from pulmonary embolism two months following surgery in a patient who developed catatonia one week after her second operative procedure. In all other instances, complications have consisted of minor disturbances of orientation, drowsiness, transient rejection of food and fluids, and temporary bowel or bladder incontinence. There have been no instances of hemiplegia, postoperative convulsions or profound changes in intellectual function of more than temporary duration.

Summary of Results

The disabling features of Parkinson's disease that are due to tremor and rigidity may be abolished or ameliorated by the production of a surgical lesion in the region of the medial globus pallidus. One or more surgical lesions may be required to produce the desired effect. In the absence of obvious contraindication to elective surgery the operation can be performed with only slight risk and without prolonged surgical morbidity. While salutary results may be anticipated in regard to gait, manual dexterity and quiescence of tremor, little or no improvement may be expected in facial expression, speech slurring, drooling of saliva and dysphagia.

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Advances In Diagnosis Of the Malabsorption Syndrome

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Recent advances in screening tests for the diagnosis of the malabsorption syndrome of enteric origin allowing early recognition of the steatorrheas are discussed and an illustrative case is presented.

THE malabsorption syndromes are characterized by steatorrhea. Loss of more than 10 grams per day—day after day—of fat can be considered steatorrhea. The normal adult stool contains from 5 to 7 grams of fat on the usual diet.

The malabsorption syndrome may be a consequence of digestive faults, such as pancreatic insufficiency or biliary insufficiency, or it may be of enteric origin. Those of enteric origin may be primary malabsorption states, which include: celiac disease, tropical sprue and nontropical sprue.

The secondary malabsorption states are those characterized by specific disease of the small bowel, such as: Whipple's disease, regional enteritis and postsurgical situations, such as extensive small bowel resection and short circuiting blind loop operations.

This discussion will be limited to the primary malabsorption syndromes.

Features of Primary Malabsorption

Celiac disease and many instances of nontropical sprue[1,2] fall into the category of gluten induced enteropathy. In addition to steatorrhea, these syndromes have additional features which include: lassitude, anorexia, loss of weight, anemia, ulcerated tongue and buccal mucous membrane, bone changes, or stunted growth. All, or none of these, in addition to steatorrhea may be present.

In general, in the malabsorption syndromes of enteric origin, in addition to steatorrhea, the following are frequent laboratory abnormalities: Flat oral glucose tolerance curve, hypoproteinemia, frequent hypoprothrombinemia, hypocalcemia and intestinal roentgenologic features generally listed under those of "deficiency" pattern.

In celiac disease, anemia is common and usually of an iron deficiency type. In tropical and nontropical sprue, anemia also is frequent and in approximately two-thirds this is of a nutritional macrocytic type.

Special laboratory procedures to aid in the diagnosis of malabsorption are: Xylose absorption, vitamin A absorption, butter absorption and determination of blood carotene. These latter tests are adequate as screening procedures. Determination of fecal fat content necessitates collection of the stool over several days' time and, in turn, complicated handling of the stool by laboratory personnel for determination of fat or fatty acid content.

Xylose and Carotene Tests

The xylose tolerance test depends upon the fact that D-xylose is poorly absorbed after oral administration in various types of malabsorption syndrome.[3] Following the giving of this material by mouth, the blood or urinary levels can be determined. Preferably the urinary determination is performed. In this procedure, the patient drinks 25 grams of D-xylose which has been dissolved in 500 ml. of water. All urine is then saved for the next five hours, including the specimen at the end of the five-

hour period. Normally, the adult in five hours' time puts out from 4.4 to 6.8 grams of D-xylose. In the malabsorption states, generally 3 grams or less are excreted in the five-hour period.

There is a parallelism between the abnormality in fecal fat excretion and that in the xylose test response. Upon treatment of the patient having nontropical sprue with a gluten-free diet, the xylose absorption usually becomes normal. This test is simple to perform, both from the patient standpoint and from the laboratory standpoint, and has a high degree of accuracy as well as reproducibility.

Another simple screening procedure is the determination of the serum carotene level.[4] Unlike vitamin A, which is rapidly absorbed, carotene is a slowly absorbed fat soluble material normally present in the diet. The body stores carotene very poorly, and depletion studies using normal individuals who received a diet low in carotene and vitamin A consistently demonstrated low levels of blood carotene within one week. The blood vitamin A levels were unaffected up to six months or longer. In the normal individual, the blood carotene is fairly constant within a given range.

The normal serum level is greater than 70 micrograms. Levels of 30—70 are considered consistent with moderate depletion, and 30 and below are considered severe depletion. A low plasma carotene will be found in intrinsic defects of absorption, or in secondary defects of intestinal absorption, and also in the absence of adequate quantities of bile and pancreatic juice in the bowel. Hence, the test is not a differential diagnostic procedure and merely is a rapid, easily performed screening procedure.

It is to be noted that the xylose tolerance test, generally, is normal in pancreatic disease and is abnormal in diseases primarily or secondarily involving the small intestine.

Butter Absorption and Vitamin A Tests

Another very simple screening procedure which is abnormal in the enteric malabsorption syndrome is the butter absorption test.[5] In the adult, breakfast consists of 30 grams of butter, two pieces of toast, 100 ml. of fruit juice, and coffee with sugar. A fasting serum sample is taken, and samples are taken at 2, 3, 4, and 5 hours following the ingestion of the butter. The serum is read at a wave-length of 650. A reading of any of the samples greater than 0.1 optical density with the fasting serum sample being used as a blank is considered normal.

The determination of the serum vitamin A level[5] is a rather easy laboratory determination; however, it necessitates having within one's laboratory a UV attachment to a rather elaborate photometer, such as the Beckman DU photometer. This test frequently is used, however, as a screening procedure. In adults, following ingestion of 3000 international units of vitamin A as fish or liver oil concentrate, the serum value should exceed 85 micrograms at 5 hours, and 125 micrograms at 7 hours. If the 5-hour level is less than 75 micrograms, it is considered abnormal.

Isotopic studies are also available in the form of I-131 labeled fat. Radio-active fat absorption may be studied in one of two ways: (1) determination in stool of the amount of unabsorbed radioactive fat, or (2) determination of absorbed radioactive fat in blood. The latter determination may be reported as the percentage absorbed or as an over-all curve depicting absorption.[6]

Biopsy

Lastly, in the last few years, peroral intestinal biopsy has been introduced by means of the Shiner Rubin biopsy or the Crosby tube.[7,8,9] Until the introduction of these instruments, the intestinal pathology in the malabsorption syndromes of enteric origin had only been described at autopsy. Findings at autopsy were frequently obscured due to the presence of post-mortem autolysis. Surgical exploration, simply for biopsy of the small bowel, has been and is considered too formidable a procedure for study of most patients with the malabsorption syndrome.

Case Presentation

This 69-year-old white male was admitted to the hospital on 7 February 1960, with a history of weakness, with alternating constipation and diarrhea for approximately ten months. He apparently was in good health until the age of about 28 or 29 years, when he first noted aching in his stomach with some constipation. Throughout the years, numerous gastrointestinal x-ray studies had been taken. Diarrhea in the past few years had been frequent and diffi-

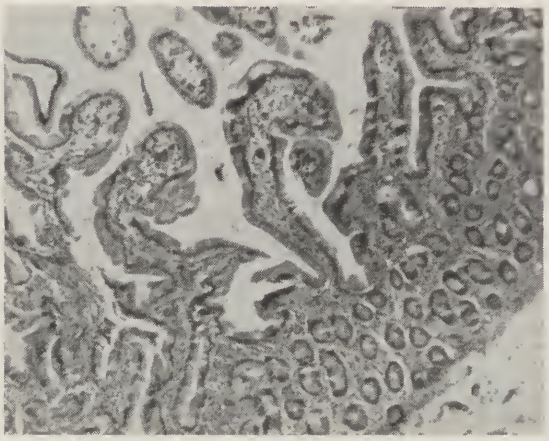


Figure 1

Normal jejunal histology. The mucosa has numerous feathery villi and an orderly columnar epithelial arrangement.

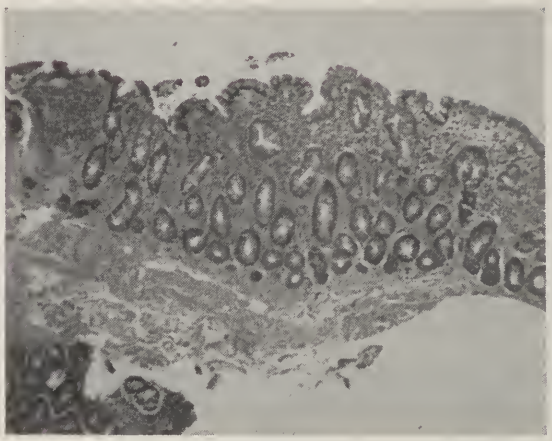


Figure 2

Jejunal biopsy showing marked flattening of the villi together with a dense infiltration of the lamina with inflammatory cells.

cult to control. Numerous medications had been prescribed. He stated that his father had similar difficulty, and a sister had many food intolerances. At no time was a history of bloody stools or dark stools obtained.

On physical examination, he was a thin white male, appearing somewhat debilitated. The abdominal organs were not palpable. Gallbladder studies were normal. Gastrointestinal series revealed no abnormalities of the small intestine. The white blood count was normal, and the hemoglobin was 10.9 grams per cent following steroid and Vitamin B_{12} therapy. The Xylose tolerance test revealed excretion of only 1.62 grams of D-Xylose with the normal, as stated previously, being around 5. The serum carotene level was 30 micrograms per cent, with the normal being around 70 micrograms or higher. Because these laboratory studies pointed to the presence of a malabsorption syndrome, a jejunal biopsy was obtained, and the following illustrates the pathology.

Figure 1 is illustrative of normal jejunal histology by tube biopsy and is presented for comparison with that noted in the Case Presentation. The normal mucosa of the jejunum shows thin feathery villi with an orderly columnar epithelial arrangement. The nuclei of the epithelial cells are arranged basally in an orderly fashion. Within the lamina, some lymphocytes, plasma cells and eosinophiles can be generally identified. In the biopsy material from the Case Presentation (Figure 2) there is flattening of the villi, a rather dense infiltration of the lamina with inflammatory cells, and irregularity in the glands. These histopathologic findings are those which have been described in instances of non-tropical sprue.

Summary

In the past several years, there have been advances in screening tests for the diagnosis of the malabsorption syndromes of enteric origin.

The Xylose tolerance test, blood carotene levels, and the butter tolerance test, in general, will serve as adequate screening procedures. If these procedures point toward intestinal abnormality, Vitamin A tolerance procedures can be done, as well as fecal fat determinations.

If means are available for obtaining an intestinal biopsy by the peroral route, distinct histopathology is usually demonstrable.

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Surgery Of Pulmonary Emphysema*

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Surgical treatment of pulmonary emphysema has been rather discouraging, but certain selected individuals can obtain marked benefit from surgical ablation of cystic portions of emphysematous lungs.

PULMONARY emphysema is still an enigma as far as surgical cure is concerned, but many individuals can be considerably improved, temporarily, with surgery. A review of my experience in the surgical treatment of pulmonary emphysema may serve to summarize the present status of the surgical treatment and suggest avenues of further investigation for improvement in the treatment of this crippling disease.

Pathogenesis

A clear understanding of the pathogenesis of the disease under attack is essential if consistent success in its therapy is to be obtained. Unfortunately, the pathogenesis of pulmonary emphysema remains obscure and highly controversial. It is occasionally seen a few months after an attack of "atypical pneumonitis" or after exposure to certain dusts. It is often seen with pulmonary fibrosis, chronic pulmonary infections, bronchial asthma, chest deformities, bronchiectasis, chronic bronchitis and pulmonary arteriosclerosis.

The atrophic changes of the lung parenchyma have been attributed to loss of pulmonary vascularity; to sustained hyperinflation of the alveoli from various causes including infection, circulatory abnormalities and constitutional predisposition; the increased intra-thoracic pressure developed to overcome resistance to the flow of air, particularly expiratory flow, as a result of air trapping from premature bronchial closure enhanced by bronchitis, exudate in the bronchi, and increased tonus of the bronchiolar muscles as with bronchial asthma; loss of normal elastic recoil of the lung; stretching of the lung periphery during the violent inspiratory efforts of coughing and lung degeneration secondary to local chronic hypoxia.

The confusion in the pathogenesis of emphysema is reflected in the multiple avenues of surgical attack used in the treatment of the disease. Kummell[1], in 1923, resected dorsal sympathetic ganglia, as did Carr and Chandler[2] in 1948. Kummell later added unilateral vagal resection to his treatment. Kappis,[3] in 1924, resected the right vagus. Leriche and Fontaine[4], in 1928, reported resection of the stellate ganglia. Thoracoplasty was used by Elloesser[5] in 1931. Freund[6], in 1936, resected the rib cartilages to render the rib cage more flexible. Rienhoff & Gay[7], in 1938, and Blades, et al[8], in 1950, revived interest in hilar denervation with stripping of the blood vessels and bronchi and division of the pulmonary ligament.

Head[9,10] reported tube drainage of the large blebs and bullae in 1949. Abbott[11,12] et al, in 1950 and 1953, combined autonomic denervation with excision of blebs and bullae. Phrenic crush was proposed by Allison[13] in 1953. Crenshaw[14,15], in 1952 and 1954, combined autonomic denervation, removal of blebs and bullae

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* *Presented before the Kentucky Division of the American College of Chest Physicians at the Annual Meeting of the Kentucky Medical Association. September 20, 1960.*



Figure 1A. Hypertrophic Emphysema, Preoperative Chest Roentgenogram



Figure 1B. Hypertrophic Emphysema, Postoperative Chest Roentgenogram

and excision of the parietal pleura to increase the blood supply to the degenerated lung. Tracheal fenestration is now being evaluated by Rockey et al.[16,17]

Treatment

In reviewing this literature it becomes apparent that those operations in which blebs or bullae are removed as part of the procedure produce the most marked and consistent improvement. Abbott, for example, noted little benefit from his denervation and bleb excisions in those patients with diffuse emphysema but did report good results if blebs or bullae were present. This is especially true when compression of adjacent lung tissue is apparent as in the so called "disappearing lung syndrome."

Most of these unfortunate individuals with emphysema can be helped considerably by medical therapy supervised by a patient, understanding, not easily discouraged physician, particularly if they stop smoking. Bronchodilators, secretion thinning drugs, breathing exercises, postural drainage and control of intercurrent infection have much to offer and should be used to their maximum benefits before seeking surgical aid.

In view of the poor results experienced by many excellent surgeons, I have had little enthusiasm for the surgical treatment of diffuse or hypertrophic emphysema. (Figure 1A) My experience with this consists of only one patient, who was found to have diffuse emphysema rather than the suspected "disappearing lung syndrome" on exploration. A lobectomy was done, with little if any improvement in his maximum breathing capacity and exercise tolerance. (Figure 1B)

I do believe, however, that those individuals who have emphysema with large blebs and bullae, particularly if associated with adjacent compression atelectasis, can be considerably improved by removal or obliteration of the larger blebs and bullae.

Case Reports

This 48-year-old colored male, totally disabled itinerant preacher was admitted to the Louisville General Hospital 10-30-53, with a three-year history of progressive dyspnea, repeated bouts of severe wheezing, orthopnea and a dry nonproductive cough. Physical examination showed severe bilateral pulmonary emphysema with bilateral hyperresonant percussion notes, marked suppression of breath



Figure 2A. "Disappearing Lung Syndrome" Preoperative Chest Roentgenogram

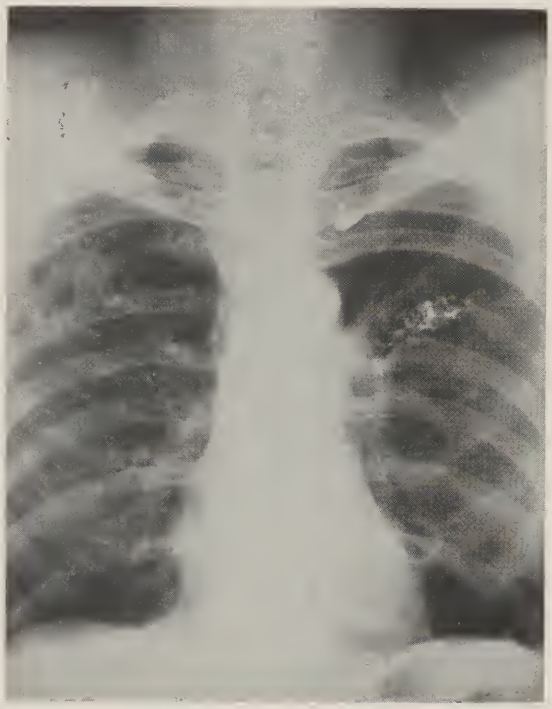


Figure 2B. "Disappearing Lung Syndrome" Postoperative Chest Roentgenogram

sounds and moderate prolongation of the expiratory phase of respiration. Chest X-rays showed numerous large emphysematous blebs and bullae bilaterally with only an estimated 25 to 30% functioning lung tissue remaining. (Figure 2A) Unfortunately the only pulmonary function study done was a vital capacity which was recorded as 45%.

Ten days after admission several large blebs and bullae arising from the upper and middle lobes of the right lung were excised. His post-operative course was uneventful, and he was discharged three weeks after operation with advice to return in three months for excision of the blebs of his left lung. He was readmitted 2-16-54 in good general condition with moderate improvement of his dyspnea. Three days later several large blebs and bullae were removed from his left lung. His post-operative course was complicated by slow re-expansion of the remaining lung due to persistent air leak. Expansion was finally obtained some two months after operation and he was discharged with a small apical empyema space still present with tube drainage. The space was gradually obliterated and all tubes were removed some four months later.

He was last seen 1-11-56. He was in excellent physical condition and stated he was working full time at his preaching with no limitations. He still had an occasional mild upper respiratory infection. (Figure 2B)

Second Case

This second case, a 41-year-old colored male yard man was admitted 10-22-54, with a history of two years of progressive dyspnea and a one-week history of bilateral flank pain and tarry stools. Physical examination revealed mild shock, with bilateral hyperresonant lung percussion notes, depression of breath sounds and generalized rebound abdominal tenderness. Red blood cell count was 3.8 million, with hemoglobin and hematocrit each less than 20%.

Twenty-four hours and six units of blood later an emergency subtotal gastrectomy with excision of a bleeding duodenal ulcer was done. On return to the ward severe respiratory insufficiency soon became apparent. Emergency tube drainage of some of the larger lung blebs was requested to increase the respiratory exchange, but on advice of the thoracic surgeon a tracheostomy was done. His respiratory difficulties were corrected but marked exertional dyspnea persisted. The tracheostomy tube

was removed two weeks later and he was discharged about three weeks post-operatively, still severely dyspneic, to return in six to eight weeks for excision of pulmonary blebs.

He was readmitted five months later with a six weeks history of severe peri-umbilical pain and tarry stools following a five day drinking spree and a four weeks history of severe shortness of breath and pedal edema. Physical examination showed marked dyspnea and pulmonary emphysema. X-rays revealed a jejunal marginal ulcer and large blebs and bullae of the lungs bilaterally. Ten days later several large blebs arising from the right upper lobe were excised and a vagotomy done. Shortly following surgery, tracheostomy was again required because of severe dyspnea. Considerable difficulty with abdominal distention and intestinal ileus was experienced for about ten days. The tracheostomy tube was removed three weeks post-operatively. A small apical space persisted but was obliterated with tube drainage within eight weeks post-operatively.

He was last seen 8-2-60. He has returned to his regular occupation with no complaints of shortness of breath and he persistently refuses surgery on his remaining lung as he sees no need for it as concerns shortness of breath.

A third case, a 53-year-old colored male laborer was admitted to the Louisville General Hospital on 1-9-58, complaining of progressive dyspnea for 2 years. He could hardly get to the bathroom of the ward from his bed. Physical was compatible with severe bilateral pulmonary emphysema. Chest X-ray showed severe emphysema with large blebs and bullae on the right (Figure 3A). Vital capacity was 2100 cc. with 1600 cc. one second capacity and maximum breathing capacity (M.B.C.) 34.09 L/minute. Ten days after admission large blebs and cysts were excised from the right upper lobe. His post-operative course was uneventful. The tubes were removed ten days post-operatively, and the next day his vital capacity was 2500 cc. and M.B.C. 75.5 L/min. He was discharged 1-30-58. (Figure 3B) Unfortunately he has not returned for follow-up studies and we have been unable to get in touch with him.

Discussion

Three of these patients had severe pulmonary emphysema with large blebs and bullae which seemed to be compressing adjacent lung.



Figure 3A. "Disappearing Lung Syndrome Preoperative Chest Roentgenogram



Figure 3B. "Disappearing Lung Syndrome" Preoperative Chest Roentgenogram

Each of them has obtained moderate to marked amelioration of his disabling dyspnea and has returned to his former self-supporting occupation for periods of up to seven years to date. One man with diffuse hypertrophic emphysema without bleb or bullae formation had no benefit from lobectomy. I would, therefore, agree with Abbott's conclusion that patients having definite large blebs and bullae can be helped by surgery but that those with diffuse hypertrophic emphysema receive only slight temporary, if any, benefit from the surgical procedures so far proposed.

Tracheal Fenestration

Rockey is at present advocating tracheal fenestration for many of these patients. He feels that the hyperinflation of the alveoli is explained, at least in part, by partial block of the terminal bronchioles by thick mucoid secretions which the patient is unable to expel by his impaired cough mechanisms. Tracheal fenestration provides an air-tight opening which does not interfere with cough and which is readily accessible for repeated catheter aspiration of the tracheobronchial tree to remove these pathologic secretions and instill intratracheal medications as desired. He describes no difficulties in training his patients to do their own catheter aspirations.

In a report of December 1959, he reviews a series of 26 seriously disabled patients. Twenty-two of them had severe emphysema. The three-to-four-hour operation was well tolerated by all patients, with no operative mortality. Of the 22 emphysema patients, six patients were slightly improved, eight were markedly improved and discharged from the hospital but required home care, four were rehabilitated to the point that they were able to care for themselves and four were able to return to a gainful occupation. Eleven patients were alive at the time of the report, the remainder having died from 2 days to 8.5 months after surgery. Reoperation was required in 13 patients.

The operation is evidently fraught with technical difficulties. I have done no fenestrations but am seriously considering it in view of the hopeless situation of many of these individuals with the modalities at our disposal so far.

Summary

The literature in reference to the etiology and surgical treatment of pulmonary emphysema is briefly reviewed and a series of four patients reviewed. Surgery to date seems to be only slightly beneficial in diffuse hypertrophic emphysema but is definitely beneficial in selected patients having large pulmonary emphysematous blebs or bullae. Preliminary reports of tracheal fenestration are encouraging but as yet its place in the surgical treatment of pulmonary emphysema is undecided.

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Some Dermatology For the Gynecologist*

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Many skin diseases involve the skin adjacent to the field in which the gynecologist works. The more common ones are herein described along with some of the basic methods of treatment of these conditions.

ANY generalized eruption may involve the area which is of particular concern to the gynecologist. Many skin eruptions, such as exfoliative dermatitis, psoriasis, alopecia, drug eruptions, lichen planus and tumor metastasis, may occur on other arcas of the body as well as on the genital area. Skin problems prone to occur here will be emphasized. I will completely exclude venereal lesions.

A recent volume entitled "The Non-Venereal Diseases of the Genitals" written by Fritz T. Collomon and John Wilson of Philadelphia, and published by the Thomas Company (1956) covers much of the field quite well.

It is obvious that there are certain anatomical differences in the area about the vulva. There are sweat glands over the entire body called the eccrine glands. In addition, there is a special type of sweat gland called the apocrine sweat gland. These occur only in the axilla, about the nipples, and in thc area of the external genitalia, particularly over the labia, These glands develop at adolescence and are much deeper than the eccrine glands. The chemistry of their sweat is different and they account for a good part of the malodor. It is the action of bacteria on sweat that produces a distinctive body odor. Body odor varies tremendously in different individuals.

Certain diseases involve the apocrine gland bearing areas and may involve thc ducts as well as the glands themselves. In addition, these areas are quite sensitive and well supplied with nerves and blood vessels. This accounts for the severity of pruritis when it occurs here. Furthermore, and perhaps more important, many psychogenic influences involve the genital area.

Inflammations

1. Fungus Infections.

There are definite differences between fungi and bacteria. The principal ones are that fungi grow more slowly, they prefer an acid medium, and will grow much better at room temperature than when incubated. The importance of fungi has increased since the advent of antibiotics, the general use of which has at times caused a flaring of fungus infection. Antibiotics effective against certain fungi have now been developed. Fungus infections are far more common and important than generally believed.

a. Tinea cruris is one of the more common infections. It is more frcquent in the male than in the female and in certain individuals whose skin and sweat have a chemistry favorable to the growth of these fungi. The same fungi that cause epidermophytosis at times involve the groin. A sharply demarcated, erythematous eruption occurs about the vulva with extension often occurring out over the inner thighs. Acute phases will usually respond to bland ointments,

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and then one can use one of the newer fungicidal agents. After it has cleared, I often prescribe a fungicidal drying power as a prophylactic measure. Many preparations are available and one need not resort to the stronger fungicides or to dyes. It is unfortunate that some of the preparations containing dyes have become so widely used. They have the disadvantage of not only staining clothes but also of masking inflammation.

b. Tinea versicolor is a fungus infection caused by Microsporin furfur. It usually produces brown, scaly patches over the trunk but may involve the vulvar area. It is seldom limited to the vulva but may be. It responds very readily to topical fungicides. I often prescribe tincture of Asterol® for local applications. Though it responds promptly, it often recurs, particularly when there is profuse sweating. For this reason I have the patients use the preparation for some months after the eruption has apparently receded. They can best do this directly after bathing. It is always worse in warm weather as are many fungus infections.

c. Monilial infections. Since monilia are present on most skins as well as in saliva, stool or vagina, they usually are saprophytic. They may at times produce disease, particularly when they overgrow the bacterial population. This is prone to occur after the use of antibiotics. I am sure many cases of pruritis of the vulva are the result of monilial overgrowth. Some have no relationship to the use of antibiotics or diabetes and those of us in practice for many years saw such infections long before the advent of antibiotics. In obese individuals who perspire a great deal, this type of intertrigo may occur beneath pendulous breasts as well as between large flabby thighs and folds of fat of the lower abdomen.

Control of Monilia

One of the most effective agents for the control of monilia is the antibiotic nystatin. I often use it in combination with a steroid as Mycolog® cream or ointment. There is also available another antibiotic, amphotericin that has similar action. Unfortunately both of these drugs are poorly absorbed from the intestinal tract so that their oral use is very limited. Sometimes in children, given in large doses, they may be of value. They are also used to help overcome the over growth of monilia in the intestinal tract. Of course, amphotericin may be given intravenously in severe cases.

Griseofulvin has recently become available as a fungicide for internal use. It has been most effective in certain fungus infections, but unfortunately there are many that are not amenable. Also, unfortunately, it has been found not to be too effective in the control of epidermophytosis and tinea cruris. It is of some help, however, and when patients are quite uncomfortable, I have them take this antibiotic in adequate doses for a month or two. It seems to be of value when supplemented by topical therapy. From the standpoint of the fungus infections under discussion here, it is indeed unfortunate that it does not work as well as was originally thought. Its most effective usage has been for tinea capitis, onychomycosis and some other types of fungus infections.

Virus Infections

1. Herpes Simplex. This virus infection is quite common and difficult to manage. It tends to recur in the same area, producing burning and vesicles. These rupture, leaving small groups of superficial ulcers. It commonly recurs over a period of time. This virus is entirely different from that which causes herpes zoster. Unfortunately, little investigative work has been done with it. It is interesting that when this virus is injected into animals it will produce a highly malignant type of encephalitis in a large percentage of innoculations. Fortunately, in humans it apparently doesn't cause this complication. Tincture of camphor has been used for many years and any antiseptic drying agent will be of value. I use a drying lotion containing Vioform® and may at times use steriod creams or lotions that are drying. Around the eyes, steriod creams are clearly contraindicated in the management of this virus infection. I have never seen difficulty from its use elsewhere.

2. Condyloma acuminata. This type of wart unfortunately has been mistakenly associated with venery. There is no connection, and it probably is caused by the same virus that causes warts on other areas of the body. Local destructive methods are needed for their removal. If a large amount of discharge is present, and this is often the case, its control will help

in the management of the warts. Sometimes, when they are quite extensive, surgical excision is necessary. They do, however, tend to recur and may do so some months after their removal. This virus infection may have a long incubation period.

Podophyllin has been used in their destruction. The 20% preparation that is on the market is a little strong unless it is applied by the physician at several days to weekly intervals. When used by the patient it may cause local irritation and discomfort. If I have the patient apply this preparation, I usually use a half of one per cent podophyllin in tincture of benzoin and have them paint it on the area once or twice a day depending on their tolerence. Sometimes it works most effectively. It is very interesting that it works so well on warts in this area but does not work well on warts in other areas of the body.

Bacterial Infections

1 Furuncles and Carbuncles. Pyogenic infections caused by certain strains of staphylococci have assumed major importance in recent years. These lesions are prone to occur in areas in which the gynecologist works. This partially is due to the fact that there are present large hair follicles and sebaceous glands. It is always best, of course, to type the strain and get sensitivity tests to the antibiotics. It has been my experience that novobiocin and Declomycin® are effective antibiotics for the strains commonly seen.

2. Erythema multiforme and urticaria secondary to infection. The reason I particularly mention these entities is that we see them at times late in pregnancy. During the last trimester many individuals have pruritis. Some have frank urticaria and others an erythema multiforme-type of reaction. Steroids are definitely indicated and usually make the individual more comfortable. In the milder cases topical antipruritics can be used along with systemic antihistamines and the patient will recover even before pregnancy ends. Others, however, will go on for six or eight weeks after delivery. Of course, erythema multiforme and urticaria can come from many causes.

3. Fox-Fordyce Disease. This type of pruritis probably is due to an infection in the aprocrine gland-bearing area. There are undoubtedly neurogenic elements involved, but it must be related to the presence of this type of sweat. There is marked pruritis and it is often difficult to treat. Sometimes judiciously used superficial X-ray therapy is of great value. Topical steroids also help.

4. Hydradenitis suppurative. This infection in the aprocrine sweat glands is much more common than generally believed. Deep and "blind" painful boils are produced. The eruption tends to recur with scarring and keloid formation. Sometimes it gets so severe it requires surgical excision. Antiobiotics given internally are often of value, but once abscesses occur it takes more than this to control it. At times nothing will work like superficial X-ray therapy.

Tumors

1. Sebaceous Cysts. Where there are large hair follicles and large oil glands such tumors are prone to occur. It is not uncommon to have a patient consult us because of a "lump" on the labia or adjacent area. These people, of course, are educated to be looking for malignancy. Cysts usually require surgical excision for their removal; however, if they become secondarily infected and discharge pus, the scarring may destroy the cyst. More often they spontaneously regress.

2. Nevi. Certain individuals are prone to develop nevi. There is a familial tendency. In a general way, if nevi are hairy and elevated above the surface they are less apt to become malignant. My main reason for emphasizing this is that I know it is common practice for obstetricians or gynecologists to remove lesions from the area while the patient is under an anesthesia for some other problem.

I have seen on one occasion a pigmented lesion, incompletely removed by an obstetrician, that proved to be a very malignant melanoma. Of course, it might have been malignant before he ever touched the lesion and it is not felt the trauma of excision can induce malignancy. There are, unfortunately, some plastic surgeons who feel it may. At any rate, if pigmented lesions of the skin are to be removed it should be done widely and thoroughly. They are probably one of the most common of all skin tumors and fortunately for all of us only a very tiny percentage of them ever become malignant.

3. Cutaneous tags. These little pedunculated lesions are common in the area and can readily be destroyed by several means. I commonly use the fulguration spark.

4. Pre-cancerous lesions. This is an unfortunate term because it infers that all of them become cancerous. Fortunately this is far from the truth.

a. Leukoplakia. This is a reversible process. When it is accompanied by atrophy it is a little less apt to reverse, but treatment is of value. I have found very small percentages of estrogen substance in a bland cream to help some. When pruritis accompanies the phenomenon (and this is common) it is more difficult to manage. Topical steroids seem to have little effect.

b. Kraurosis Vulva. I have used an estrogen cream topically on this condition and apparently with some benefit. To me it is most interesting that even a 1% Dinesterol cream can be absorbed from a small area. It may even at times produce vaginal bleeding and breast enlargement. I have seen this on several occasions and as I go along tend to use the Dinesterol in less and less strengths. I am now on about ¼ of 1%.

c. Seborrheic Keratoses. These are pigmented, warty lesions that are confusing at times. They are usually scaly, elevated above the surface and rarely become malignant. They can be destroyed by several means and since scarring is not a big factor in this area, this consideration need not influence the choice of modality. I commonly destroy them by freezing with liquid nitrogen.

d. Chloasma. This type of increased pigmentation of the skin is common. It occurs during pregnancy, but also may occur at any time. The forehead and cheeks are the common sites. In recent years there has become available a preparation called Benoquin®. This chemical, when applied in lotion or cream form over a period of two or three months, will cause a fading of the pigmentation of the skin. I prefer the cream. About one in ten patients will be irritated by this preparation and if that be the case then it must be stopped. Obviously, exposure to the sun aggravates the condition.

5. Malignant lesions.

a. Basal cell carcinomata are rare in this area. I have seen several cases, however. Fortunately their degree of malignancy is low and they can be removed by any modality that will completely destroy them. The squamous cell carcinoma and melanoma need not be mentioned further for it is felt the gynecologist is quite aware of them.

Allergies

Contact dermatitis. This is a type of externally produced dermatitis, caused by exposure to a chemical to which the patient is sensitive. In this area I have seen eruptions from a sanitary belt, from the sanitary pad itself, from underclothes, girdles, etc. Usually the causative chemicals involved are some resins applied to the material, perfume used in or on them or some other substance in the dye of the material. I have several photographs in my collection of contact dermatitis from rubber prophylactics. In addition, and this is not uncommon, patients develop dermatitis around the external gentialia from medications used in douching. I have seen a number of cases of acute contact dermatitis from various antiseptics used to "prep" patients before operation. The organic mercurials may cause trouble, producing a rather acute contact dermatitis.

Pruritis Vulvae Et Ani

This entity has been a most confusing one to gynecologists and dermatologists alike. It can come from many causes. I recently treated an Italian woman about 60 years of age with intense pruritis vulva and many excoriations. On two occasions urine examination for sugar was done and found to be negative. After unsuccessful therapy for about a month she dropped from sight. About two months later I saw her on the service at Cincinnati General Hospital and found her to have a blood sugar well over 300 mgs. per cent. Ever since I have routinely been doing blood sugars on patients with pruritis vulvae. Occasionally one finds such a high renal threshold resulting in a completely negative urine in a diabetic. Mild elevations may be significant as a predisposing factor.

Pruritis vulva may vary all the way from no noticeable lesions whatsoever to a bright red, oozing, erythematous eruption that is incapacitating. I think a common cause of many

cases is a fungus infection, although others undoubtedly are either caused by or are aggravated by psychogenic factors. The latter are particularly prone to occur in the unmarried female between 35 and 50 years of age. From this one can see that the treatment will vary depending on the cause. Many of them seen by the dermatologist are over treated and hence require soothing preparations such as plain zince oxide ointment, cold compresses, steroid creams and even at times judiciously used x-ray therapy of a superficial type.

One must be aware of the psychogenic factors involved in skin eruptions in this area. Itching is particularly embarrassing to these patients, not only because they are unable to scratch it but also because of a whole host of phobias they develop. Itching is always a very variable symptom but particularily is this true in this area we are discussing. There are many nerve endings here and as a result itching may be severe. Furthermore, many individuals mask their symptoms and do not even mention them to the physician.

The importance of worms, in children, as a cause of pruritis is often overlooked. On several occasions I have found worms in children who had been treated for some time because of itching in the perianal and vulvar areas.

Infestations have become rather rare. We still see pediculosis pubis but it is of infrequent occurence compared to that which it was some years ago. Scabies has almost disappeared from the practice of dermatology. We used to see many cases some 20 years ago, but now we might see a case every year or two. Why has this occurred? Is it the generalized use of detergents as cleansing agents? Is it that people are cleaner than they used to be? As a matter of fact, I don't think any of us know why.

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Manuscripts should be submitted in duplicate to The Journal of KSMA, an original copy and one carbon, and typed with double spacing. Maximum length of an article should not exceed 4500 words; the Board of Consultants on Scientific Articles prefers that they be briefer than this when possible.

In submitting a manuscript, the author is requested to include a concise summary, not to exceed 35 words, to be used as a sub-title when the article is published in The Journal. The purpose of the summary is to create additional interest and encourage greater readership.

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CASE DISCUSSIONS
From The
University of Louisville Hospitals

Children's Hospital

Hypertrophy Of The Clitoris In An Infant

Stiles W. Allen, M.D.*

Case Presentation

L. D. is a female infant admitted to the Children's Hospital for the first time at the age of 13 months. She was referred to the hospital by her family physician for an "endocrine workup" because of an enlarged clitoris. Her mother had first become concerned about the size of the clitoris when the infant was 7 months of age but had not been sufficiently worried about it to seek medical advice until she was 13 months old. In retrospect her mother felt that the clitoris had been large since birth and had not enlarged further since the age of 7 months. The infant is said to have been in good general health since birth and her developmental history was within normal limits.

The mother was 28 years old and is said to have been in good general health. She had had two previous pregnancies each of which terminated in miscarriage. The first pregnancy terminated in this manner at 6 months gestation and four months following surgery for an "ovarian cyst." The second pregnancy terminated at 2½ months gestation, following the first miscarriage by 11 months. The third pregnancy, which produced the infant to be considered here, was complicated from the first month by mild vaginal bleeding. At first she was simply advised to stay off her feet as much as possible; however, when the bleeding continued during the second month she was started on Norluten,® a derivitive of 19-nortestosterone, in a dose of 5 mgm. twice daily which she continued to take until the time of delivery of this infant. Labor and delivery were uneventful and the infant was apparently normal at birth. No reference was made as to the size of the clitoris. The infant was full term and weighed 7 lbs. 1½ ozs. at birth. The family history was noncontributory.

Physical Examination

The physical examination at the time of her first admission to the Children's Hospital revealed a well developed and well nourished female infant weighing 24 lbs. 6 ozs. at a stated age of 13 months. Her blood pressure was 85/70, pulse 108/min. and respirations 30/min. The clitoris was enlarged but of otherwise normal structure. The remainder of the external genitalia was normal for a female infant of this age. There was a separate urethral and vaginal orifice, each of which was in normal position. The remainder of the physical examination was within normal limits.

Laboratory

The initial laboratory examinations made on this infant revealed:

The initial laboratory examinations made on this infant revealed:

WBC	8,950	Blood Chemistries		Urinolysis—Sp. gr. 1.020
stabs.	3	Sodium 125 mEq/L		Albumin—Negotive
segs	42	Potassium 4.3 mEq/L		Sugor—Negotive
lymphs	52	Chloride 107 mEq/L		Aceton—Negotive
monos	1	CO_2 19.7 mEq/L		Cellulor Elements—
eos.	2			Negative WBC
Hemoglobin 9.8 Gm%				Occ. Squomous cells

A 24 hour urine sample was collected and examined for 17-ketosteroids which were reported as 1.91 mgm/ 24 hrs. A bone survey for ossification centers was made and interpreted as being within the normal range for this infant's age. An intravenous pyelogram and cystogram were done and revealed normal gross anatomy of the urinary tract with no communication with the vagina. A smear of scrap-

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ings from the buccal mucosa was examined and revealed the nuclei to be sex chromatin positive or of female origin.

A diagnosis was made at this time of hypertrophy of the clitoris possibly secondary to prenatal maternal ingestion of an androgenic substance (Norluten). She was discharged to return in two months for re-evaluation.

She was admitted to the Children's Hospital for the second time at 15 months of age. She had been well in the interim since her first admission. Her mother did not feel that the clitoris had changed in size since the first admission. Physical admission at this time was essentially unchanged. A long bone survey was done for bone age and was again within normal limits for her age. Urinary 17-ketosteroids were repeated and were reported as 0.65 mgm/ 24 hrs.

She was admitted for a third time at 18 months of age and the above studies repeated which were again found to be within normal limits. She was seen as an outpatient at the age of two years and found to be doing well. The enlargement of the clitoris was still present. She has been referred to the care of her private physician.

Discussion

This case illustrates the problem with which the physician is faced when presented an infant with hypertrophy of the clitoris. The pressures of our modern day culture make it mandatory for him to decide as quickly as possible what the underlying etiology responsible for the enlarged phallus is and to institute appropriate therapy if any is indicated. This necessitates that he have a clear understanding of the possible etiologies involved and be able to carry out the necessary investigations to decide what factors are at play in a given case.

The physician must be very cautious in his counseling of the family of an infant with clitoral hypertrophy or, for that matter, any abnormality of the genitalia, as they frequently regard the child as some sort of freak and something to be ashamed of. The physician should carefully explain what c a u s e d the anomaly and above all what can be done about it and what the future holds for the child.

The causes as far as we know them today of enlargement of the clitoris in an infant may be outlined as follows:

1. The normal, wide variation in size of the clitoris in infancy.
2. Neoplasm involving the clitoris.
3. Endocrine dysfunction such as hyperplasia of the adrenals.
4. Induced in embryo by prenatal maternal hormone therapy.
5. Idiopathic benign hypertrophy.

As has been stated above there is great variation in size of the clitoris in infancy. The clitoris in infancy and childhood is proportionately much larger than the remainder of the external genitalia than it is in the adult. The greatest growth of the clitoris occurs in infancy and childhood and is much slower during adolescence than the growth of the remainder of the external genitalia. From birth to adulthood the clitoris grows only about ¼ to ¾ inch in length and ⅛ to ⅜ inch in diameter. This point is made only to emphasize that in dealing with an infant suspected of having an enlarged clitoris one must keep in mind the normal wide variation in size.

Neoplasms of the clitoris are quite rare, especially in children, and fall mainly into three groups: lipomas, hemangioendotheliomas, and neurofibromas. A clitoris with a distorted, irregular shape should be suspected of being invaded with a neoplasm and a biopsy taken and the necessary surgical procedures for its removal carried out.

Pseudohermaphroditism

Female pseudohermaphroditism due to congenital virilizing adrenal hyperplasia is now a well recognized condition. The defect in this condition is confined to varying degrees of masculinization of the external genitalia. The ovaries are normal and the genital ducts are differentiated along the normal female pattern into vagina, uterus and fallopian tubes. Masculinization occuring in embryo results in an enlarged phallus and varying degrees of fusion of the labioscrotal folds. If this fusion is of minor degree, separate urethral and vaginal orifices are usually present. More complete fusion results in the formation of a urogenital sinus which may have its single orifice at the base, on the shaft or even on the tip of the phallus. Such a female infant may readily be mistaken for a male with hypospadius or even in severe cases for a normal male with simple cryptorchism.

This condition of masculinization of a female infant due to adrenal hyperplasia will result in

the excretion of abnormally high levels of 17-ketosteroids, and other products of adrenal origin, in the urine. The osseous development of these children is advanced beyond that expected for their age and this degree of accelerated osseous development, as well as the degree of masculinization, continues to advance in the untreated or inadequately controlled patient. These patients may require exploratory laporatomy for final diagnosis and to rule out the rare case of true hermaphroditism which possess both ovarian and testicular tissue. Many of these patients have other problems associated with adrenal hyperfunction such as disturbance of normal electrolyte metabolism and hypertension. Further discussion of this rather complex problem is beyond the scope of this case discussion.

Anatomic findings identical to those described above occuring in female pseudohermaphroditism secondary to adrenal hyperplasia may also be seen in female infants who have no abnormality of adrenal function. These cases fall into the classification of benign hypertrophy of the clitoris with varying degrees of fusion of the labioscrotal folds. These may be idiopathic in origin or, as has recently been pointed out by several workers, may be secondary to androgenic stimulation induced by prenatal maternal hormone therapy. Among the theories put forward to explain some of the cases of idiopathic hypertrophy of the clitoris the best accepted have been: 1. Trauma associated with chronic irritation caused by such things as masturbation and frequent scratching. 2. More recently it has been postulated that this may be caused by abnormal metabolism in some gravid women of their endogenous progesterone to form androgens. This theory is supported by the fact that progesterone may be a precursor of both androgens and corticosteroids.

The degree of masculinization of a female infant as a result of maternal hormone therapy is usually much less than that found in cases of adrenal hyperplasia. In some extreme cases however the masculinization had progressed to such a degree that the infant was mistaken for a male and raised as such. For any degree of fusion of the labioscrotal folds to occur the hormone therapy must have been instituted before the twelfth week of gestation. Phallic enlargement, however, may occur anytime androgenic activity is exerted over a sufficient length of time. It had originally been thought that masculinization of a female fetus by the administration of androgenic substances to a gravid female represented abnormal metabolism of these substances by the fetus. The fact that no virilization of the mother occurred was used in support of this hypothesis. However, it is now felt that this phenomenon indicates that the end-organs of the developing fetus are relatively more sensitive to androgenic stimulation than are those of the adult. There now seems to be little doubt that masculinization of a female fetus can result from doses of androgenic substances small enough to produce no detectable change in the mother.

There are two preparations frequently administered to pregnant women that have been said to cause masculinization of a female offspring. These are Norluten® and 17-a-ethinyltestosterone. A third compound, Enovid ®, has recently also been thought to produce some degree of masculinization of a female fetus. Norluten® has been noted to have much more androgenic effect than either 17-a-ethinyltestosterone or Enovid ®. Significant degrees of masculinization of a female fetus have been noted with doses of 17-a-ethinyltestosterone of 20 mgm to 250 mgm daily and of Norluten® of 10 mgm to 40 mgm daily. High degrees of masculinization have been noted with doses of Norluten® as low as 15 mgm daily.

Cases of benign hypertrophy of the clitoris with varying degrees of fusion of the labioscrotal folds may be differentiated from those caused by adrenal hyperplasia by the fact that in the benign form the level of excretion of 17-ketosteroids in the urine is within normal limits, there is no acceleration of osseous development, the degree of masculinization does not progress after birth and there is no other evidence of adrenal abnormality.

Determination of Genetic Sex

Probably the foremost question in the minds of the parents, and often of the attending physician presented with an infant with some degree of masculinization is what is the actual genetic sex of the infant. Attempting to determine this, even by careful examination of the external genitalia, may be both difficult and completely misleading. An incorrect diagnosis of the sex of a child, only to later discover the error, can be extremely traumatic for the parents as well as the child. The physician must make every effort to determine the real

sex of the infant as early as possible but he also must be reasonably confident in his diagnosis before informing the parents. Only when this has been done can he outline to the parents the best course of management of the infant.

The single most useful diagnostic procedure available at present for accurately determining the genetic sex of an individual in cases of intersexuality is the histologic examination of tissue from this individual. The cell nuclei in all human tissue of female origin contain a sex chromatin body. This structure may be identified by routine histologic methods as a plano-convex mass about one micron in diameter, characteristically lying in close approximation to the nuclear membrane. This body has been found to be composed largely of desoxyribonucleic acid. Tissue of male origin rarely has nuclei containing chromatin material large enough to be mistaken for this typical sex chromatin. Thus, by this relatively simple technique, tissue of male origin can be differentiated from that of female origin. This technique may be applied to all human tissue, however, the simplest and most readily available is mucosal cells obtained from buccal scrapings.

Blood smears also have the advantage of being easily obtained but present somewhat more difficulty in interpretation. It has been found that 30% to 60% of suitable nuclei of female origin contain this chromatin body. It is usually customary to refer to female nuclear sex as chromatin positive and to male nuclear sex as chromatin negative. Recent work indicates that this sex chromatin body represents the heterochromatic portions of the two X-chromosomes present in the female and is thus absent in the male. This conclusion has come largely from chromosome analysis of cases of Klinefelter's and Turner's syndromes. The procedure of sex determination by this method should be carried out in all cases in which there are abnormalities of the external genitalia. When a urogenital sinus is also present, it is generally advisable to perform urethroscopy to demonstrate the vagina and visualize the cervix. Occasionally exploratory laparatomy is also advisable to rule out true hermaphroditism.

Therapy

Since further virilization of the external genitalia in an infant such as the one described here does not progress after delivery there is no reason to consider therapy directed at reducing androgenic activity. The therapy in this sort of patient is two fold: 1. Counseling of the parents and possibly later the child and, 2. Surgical revision of the malformed external genitalia if such is required. The decision to attempt to correct the defect in the external genitalia should be made after careful consideration and discussion between the parents and the physician. It should be emphasized that as the child grows the size of the clitoris relative to the remainder of the external genitalia will progressively decrease. For this reason, in less severe forms of this condition, it is probably best to advise against amputation. However, if the enlarged clitoris is a constant source of psychic trauma to which the parents cannot adapt and, hence, is more likely to be of greater concern to the child amputation should be more seriously considered. If any degree of fusion of the labioscrotal folds have occurred surgical revision of this should probably be attempted. In counseling the parents of such a child, it should be emphasized to them that the child is functionally a normal female and that the chances of her leading a normal female life are very good.

The feelings of the child herself must not be overlooked and when she reaches an age at which she becomes aware of the anatomic abnormality of her genitalia, however slight this may be, the physician must be prepared to counsel her lest serious emotional problems develop. It is wise to anticipate this time and to make an attempt to prepare the parents for its appearance. Unless properly handled a rather minor abnormality of anatomy may produce a very serious emotional disturbance in the child, and occasionally in the parents.

Masculinization of a female fetus by the administration of androgenic substances to the mother during her pregnancy is not a frequent complication of this therapy, however, it is now generally agreed that it does occur and the possibility of this happening should be kept in mind by the physician who prescribes these preparations. The case here presented is meant to emphasize this point.

SPECIAL ARTICLES

The Physician's Responsibility In National Affairs

CONGRESSMAN JOHN C. WATTS*

IT is with a great deal of pride and pleasure that I thank you for honoring me with an invitation to speak to you today. I must confess I have always stood in some awe of physicians as individuals, so that a large gathering of your profession almost strikes me speechless. Almost, but not quite. For one of the tools of my trade, as it is of yours, is oral communication, and I hope I am as sincere and competent a practitioner of my profession as you are of yours.

In that respect, as in a suprisingly large number of others, our jobs have parallel goals and techniques. We in Congress, for example, are vitally interested in promoting what the Preamble to the Constitution calls "the general Welfare," a goal which I suspect is as dear to you as it is to me.

Your concern is with the ills of the human body; mine is with the ills of the body politic. Yet, while you concentrate upon the individual patient, you also care about the social implications of medical problems, just as we Members of Congress, who deal with society's problems, must also concern ourselves with the individual constituent.

As a matter of fact, Congressmen spend so much of their time running errands for constituents, answering their questions, and generally acting as their attorney before the Government, that I have often thought each district should have two Congressmen: one to service constituents, the other to study legislation and to vote.

Pride in Work

I was looking the other day at a list of the reports executive agencies are obliged to make to Congress every year or two. The list is printed in type so small it is almost unreadable, and it takes up 37 pages. If Congressmen were to read all of these, plus the hundreds of reports and hearings published by Congress itself, they would have time for little else. Well, I won't complain any further if you promise not to tell me how many medical journals you have to keep up with.

In fact I am not really complaining at all because I like my work and I am proud of it just as you are proud of yours. We have sworn ourselves, under most solemn oath, to the service of others and that is good reason for pride. In following that oath we hope to make sound diagnoses of the ills which now beset us and we hope also to find and put into practice the kind of answers that will prevent crises from developing. In politics and in medicine there is always a variety of quack remedies being peddled about against which honest men must always be alert. For the politician, as for the doctor, the problem of deciding on proper diagnosis and treatment in each specific case is seldom simple.

There is a certain similarity also in the additional burdens that have been imposed upon politicians and physicians alike by the scientific and technological advances of recent decades. For you this has meant new drugs, new treatments, more complicated procedures. For Congress it has meant grappling with the problems of a society swollen to indescribable complexity. It has meant handling a government whose role has expanded to the point where there is hardly an American whose life is not intimately touched by the hand of government. You would not believe the variety of subjects upon which

Address delivered at County Society Officers Conference in Lexington, April 6

Congress is annually requested to pass legislative judgment from atomic energy to zinc mining. During the 86th Congress more than 20,000 bills were introduced. Fortunately less than four percent of these were actually enacted, but even this represented a fantastic range of subjects.

Specialization

Now, it is manifestly impossible for any one man to be an expert in all these matters—education, labor, national defense, taxes, tariffs, government efficiency, Indian affairs, foreign aid, banking, missiles, soil conservation, housing, reclamation, water pollution, court administration, subversive activities, public health, child welfare, urban renewal—I could literally go on for hours merely naming subjects. As you might expect, Congressmen follow the lead of doctors. They specialize. They try to know something about a great many things, but they train themselves to become specially knowledgable in one or two fields. For the others, they must rely on experts and specialists. Sometimes they turn to their colleagues in Congress. Many times they turn to the professionals who are devoting their lives to the matter at hand. And it is in that connection that physicians bear a double responsibility.

I say a double responsibility because of the special nature of the oath I alluded to earlier. Let me say to you in the words of Francis Bacon that a man's duty is divided into two parts: "the common duty of every man as a man or member of a State, and the respective or special duty of every man in his profession, vocation and place." Physicians have the special duty of their profession reinforced by the special nature of their profession, a nature peculiarly altruistic.

That special duty, that double responsibility, demands that every doctor shall make his views heard. The American Medical Association has recognized this by incorporating a significant paragraph into its code of medical ethics. It appears in the section of the code devoted to the duties of physicians to the public:

> "Physicians, as good citizens, possessed of special training, should advise concerning the health of the community wherein they dwell. They should bear their part in enforcing laws of the community and in sustaining the institutions that advance the interests of humanity."

This, it seems to me, is an eminently sensible statement, which is only what one expects of doctors. As Oliver Wendell Holmes put it, "The lawyers are the cleverest men, the ministers are the most learned, and the doctors are the most sensible." Of course, Mr. Holmes just happened to be a doctor himself, but that does not detract from the sensible quality of his statement.

Doctors in Congress

In the past, physicians have carried their qualities into the arena of public affairs in surprisingly large numbers. Since 1775 more than 360 doctors have served in the United States House of Representatives and in the Senate. Five of these were signers of the Declaration of Independence. Twelve physicians have represented this great State of ours, Kentucky. This present Congress includes six members of the profession, and one of them, Representative Walter H. Judd, a Republican from Minnesota, has given us an unusually lucid statement as to why doctors should pay attention to public affairs. Mr. Judd has said:

> "First, we have to do it to insure the conditions which will enable us to practice good medicine with success and satisfaction for ourselves. Second, we have to pay some attention to public affairs in order to influence and improve conditions which adversely affect our patients. There is a third reason, in addition to what you have to do yourself, as a physician. That is to influence your future and that of your children as citizens, because before anyone is a doctor or clergyman, or businessman (and, I would add, a lawyer) he is a citizen of this republic."

It behooves you, therefore, as physicians and as citizens to offer your professional advice and criticism and to offer them forcefully and frequently. You are the ones who are intimately familiar with our national health needs. You are the men to whom we look for suggestions as to the most effective and efficient means of filling these needs. One of the alternate definitions of the word "profession," according to my dictionary, is open declaration and public avowal. The country therefore calls upon you to declare openly and to avow publicly your thoughts and opinions on national health questions. We depend upon you, and upon other professional groups in your field, to serve as our guides in the vast and complex realm of medical science.

Responsibility

In a world infected with the fear of atomic warfare, our responsibility, yours and mine, is more crushing than ever. We are both projected into the area of human survival in the atomic age. Mankind is confronted with issues that have in them a note of finality and doom hitherto unknown. Science must sit at the right hand of the legislator when he deals with such issues. The doctor, who has at least some of the answers in the event of atomic catastrophe, must give us his counsel or we are lost.

Turning to our domestic health problems, you are probably thinking to yourselves at this moment that doctors have in fact spoken out on issues. The medical profession has in recent years mounted an aggressive and forceful campaign against socialized medicine. I commend you for the vigor with which your organizations have placed before the public their views on the proposals that have been considered by Congress.

I am not, as you may know, one of those who believe that we can achieve better health for the American people by the simple act of passing legislation. It is relatively easy, I know, for a lay reformer to write into a bill what seems to him to be an ideal scheme for the proper distribution of medical services. And I also know that such plans usually neglect those imponderable human values without which good medical care cannot be made available to the American people.

I am also aware of the fact that the medical profession itself has been evolving in the direction of providing better and more widespread medical care to the public. The enormous progress in the health standards of the American people is due almost entirely to the heroic efforts of public-spirited doctors.

Let me urge you in the strongest possible terms, not to relax your efforts. We have in our country too many groups that rouse themselves to the battle only on special issues and at special moments of crisis. In the field you so honorably represent, such conduct would be disastrous. The health and well-being of our Nation demand that physicians maintain a continuing program of participation in national affairs. On the basis of past performance, I have no doubt that the medical profession will live up to its responsibilities.

Be sure to make your
Hotel Reservations now
for the 1961 Annual Meeting
September 19, 20, 21
in Louisville

EDITORIALS

Do You Want "Uncle Sam" For Your Family Doctor?*

THE longest and most dangerous step yet taken toward socialism or the welfare state in our nation in the last 25 years —and there have been many—is H.R. 4222 to provide medical care for the aged, to be paid through increasing the social security tax. If this bill becomes law, it will arm Uncle Sam with the authority, as time goes on, to become the director and dictator of your medical program.

As the bill is proposed, it is not socialism by revolution but disguise—a matter of "getting a foot in the door." No matter how the pill is sugar-coated, it adds up to socialized medicine, unless our country ends up quite differently to all other nations that have tried this government-dominated health program. They all started on a simple, modest scale and the people were assured the central government didn't want to do very much of anything except pay the bill.

England is a good example of what we mean. There the system has mounted by billions of dollars year by year. In 1956, the cost of bottles for giving away the free medicine was almost $3 million. Not a single major hospital has been built in England in 15 years. (These figures were presented by Dr. John B. Reckless, a prominent English doctor, at a recent meeting of the Kentucky Medical Association.)

In England the physician has come to be regarded as a government servant. The medical profession has been forced into production-line methods, and the close relationship between the doctor and patient has been destroyed. What is true of Great Britain is true of a number of other European nations. In all of them the medical program started in a comparatively mild sort of way, but the socialist noose has been drawn tighter year by year.

All of us are fully agreed that those who need medical help should have it promptly and sufficiently. Human disease and suffering should be cured, if possible, wherever it is found. Help is available already. A Federal grant-in-aid health program for the needy and near needy was set up by Congress last year. This program is designed to be administered locally for locally determined patients. The benefits reach out to all the aged in need—not just merely to people covered by social security. This program is voluntary and based on need alone. Therefore, all the aged who don't need help can stay independent. This plan is known as the Kerr-Mills Bill (introduced by Senator Kerr, Dem., Oklahoma, and Congressman Mills, Dem., Arkansas) and is already in operation. Why not give it a chance?

We cannot think the majority of Kentucky people want a socialist-tainted, government-administered health program. Those who do not want it should get in touch with their Senators and Congressman and let them know how they feel.

—J. E. STANFORD

**Editor's note: We are pleased to present this editorial which appeared in the May 1961 issue of Kentucky Farm Bureau News.*

Physician, Save Thyself

THE most effective and economically feasible deterrent to your own injury in an automobile collision is a simple seat belt anchored through the floor and worn every time you enter a car. Continuing apathy about personal survival on the part of many physicians endangers the population of this group which is currently in short supply and is doubly tragic in setting poor safety precedents and patterns. There is unmistakable responsibility on the part of physicians to carry leadership by example—and at times, campaign—in matters of health and physical safety. Detroit's patent interest in chrome trim, in projecting knobs, and recently in non-laminated glass for side and rear windows is not directed toward accident survival. Safety Council campaigns and auto crash research data, have similarly failed to break complacency over poor packaging of humans in our commonplace automobiles.

To place one's wife, child or friend in the aptly designated "suicide seat" to the driver's right is second to no other common accident hazard to which an individual may be subjected. It is the worst type of thoughtlessness. This suicide seat, however, and your own behind the "spear aimed at the driver's heart," can be given tremendous insurance against mortality and morbidity by installing and wearing seat belts at all times. No commercial aircraft will leave the ground unless every individual has his seat belt fastened. Accidental deaths per passenger mile in automobiles exceed those in aircraft by more than five fold; thus it is five times more vital that you never drive from the curb without seat belts in place.

Of the more than 3,000,000 individuals injured in U.S. highway accidents in 1960, over 80% involved passenger cars rather than commercial or other vehicle types and approximately 95% involved vehicles in apparently good condition. Similarly 80% of the injuries occurred on dry roads and about 85% in clear weather. Manifestly there is no statistical security in operating "good" cars under "good" conditions. It is also fatuous to think of impact absorption or protection in large fenders or wide bumpers. Well known energy absorbing materials and hydraulic bumpers have been consistently planned *out* of automobiles, thus favoring the Paragon of the Sales Curve over human survival. We have become mentally so softened by high standards of purity in drinking water or government inspected meat that we extrapolate this safety to our cars. Such is murder by apathy.

This committee, in keeping with the Cornell University crash research program, the A.M.A. Committee on Medical Aspects of Automobile Injuries, The American College of Surgeons Committee on Trauma, and the dictates of common sense, most solemnly urges each Kentucky physician to protect his own life and to lead by precept in the installation and use of seat belts in his automobile at all times.

Arthur H. Keeney, M.D., Chairman
KSMA Committee on Highway Safety

Pulmonary Infiltrates With Eosinophilia

IN 1932 Loeffler reported a series of patients with large numbers of eosinophils in the circulating blood, who sustained a brief benign illness characterized by migratory pulmonary infiltrations. These patients were free from parasites to which eosinophilia might be ascribed. Loeffler speculated on a possible relation of this disorder to tuberculosis. Within four years, in reporting additional cases, he considered this disorder as allergic.

Since that time, interested workers have complicated this simple clinical picture by adding, in large volume, other cases which have the two features of pulmonary infiltration and eosinophilia. Cases have been presented by nosological identifications that include: tropical eosinophilia, acute febrile eosinophilic asthma, eosinophilic infiltration of the lungs, familial eosinophilia, eosinophilic asthma, Weingarten's syndrome, pseudotuberculosis of the lungs, benign eosinophil leukemia (Treu), pulmonary acariasis, eosinophilic lung, pulmonary eosino-

philiosis, eosinophilia with splenomegaly, eosinophilic pneumopathy, grande eosinophilie sanguinaire, and pulmonary infiltration with eosinophilia (P.I.E. syndrome).

A review of the various articles indicates that there are many pathological processes included, with essentially the only criterion being the presence of eosinophils and of pulmonary infiltration. They reflect the interest of divers serious thinkers on the basic problems of the significance of the eosinophil, on pulmonary disease, both as a pathological entity and as a matter of the intricacies of pulmonary ventilation. There begins to emerge a pattern that the pulmonary tissue probably has specific capabilities as an eosinophil "trap," and this has been reasonably well confirmed by animal experimental work.

The clinician, as distinguished from the research worker, has certain problems in therapy and prognosis differing from the interests of the investigators of basic phenomena.

To the American clinician, there is a benefit in identifying the benign self-limited disease originally described by Loeffler. The specialist in tropical medicine would benefit from a rubric limited to a reasonably specific entity. There would seem to be merit in classifying the reported cases in four categories:

a. Loeffler's syndrome, or P.I.E. (Pulmonary Infiltration with Eosinophilemia) syndrome—A benign self-limited disease characterized by the presence of blood eosinophilia, transitory acute pulmonary infiltration, with a comparatively brief course, possibly responsive to steroid therapy.
b. Tropical cosinophilia with pulmonary infiltration (Weingarten's syndrome)— A chronic disease, with extensive infiltration which is substantially persistent, protracted prostration, and an apparently specific sensitivity to treatment with arsenic.
c. Diseases associated with eosinophilia in whom transitory pulmonary exudates may occasionally occur. This group is probably best illustrated by periarteritis nodosa.
d. Presumably unrelated diseases in which eosinophilia and transitory pulmonary infiltrates may occur, such as metastatic carcinoma of the colon, and similar curiosities.

George F. Brockman, M.D.

Hemorrhage From Leiomyomas

Six patients with smooth muscle tumors of the gastrointestinal tract are reported. These cases illustrate the peculiar tendency of leiomyomas to produce recurrent massive gastrointestinal bleeding. Benign tumors, at times as small as 2 cm. in diameter, may be associated with episodes of exsanguinating hemorrhage over a period of months or years. These tumors tend to be attached to the stomach or intestinal wall by a small pedicle and to extend as mobile masses into the peritoneal cavity. Because of their predominately extramucosal growth they are often difficult to demonstrate by x-ray. Repeated acute bouts of gastrointestinal bleeding with negative x-rays should suggest the presence of these tumors, and early exploration should be carried out since fatal hemorrhages have occurred from small benign leiomyomas.

—B. F. Huntley, A. R. Laurain and W. H. Stephenson, Archives of Internal Medicine (Aug.) 1960



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DOSAGE: The recommended initial dosage for adults is two tablets (2.5 mg. each) three or four times daily, reduced to meet the requirements of each patient as soon as the diarrhea is under control. Maintenance dosage may be as low as two tablets daily. Lomotil, brand of diphenoxylate hydrochloride with atropine sulfate, is supplied as unscored, uncoated white tablets of 2.5 mg., each containing 0.025 mg. ($\frac{1}{2400}$ grain) of atropine sulfate to discourage deliberate overdosage.

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ORGANIZATION SECTION

Guest Speakers to Highlight Annual Meeting Program

Outstanding scientific presentations by authorities from throughout the U.S., panel discussions on timely medical topics, 14 specialty group meetings, a film on cardiac massage, and selected scientific and technical exhibits are just some of the events calculated to make the 1961 KSMA Annual Meeting one you won't want to miss.

Biographical information on four of the guest speakers who will participate in the meeting has just been made available by Richard G. Elliott, M.D., Lexington, KSMA president. Following is information on speakers who will come to the meeting as guests of the Kentucky Chapter, American Academy of General Practice, the Kentucky Orthopaedic Society, the Kentucky Society of Pathologists, and the Kentucky Chapter, American College of Chest Physicians.

Guest of the Kentucky Academy of General Practice will be James Barrow, M.D., senior associate, Division of General Surgery, Henry Ford Hospital, Detroit. A 1940 graduate of the Tulane University School of Medicine, Doctor Barron received his board certification in surgery in 1949. He took his internship and residency training at Henry Ford Hospital.



James Barrow, M.D.

"Nutrition and Surgery" is the topic Doctor Barron is scheduled to discuss at the general session on Thursday, afternoon, September 21. That morning he will be a featured speaker at the specialty group meeting of the KAGP at the Columbia Auditorium. A native of Mississippi, he is the author of several articles which have appeared in national and state journals.

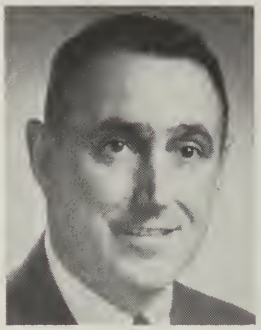
Garrett Pipkin, M.D., a native of Kansas City, Mo., and a graduate of Washington University Medical School, St. Louis in 1930, will be the guest of the Kentucky Orthopaedic Society. Doctor Pipkin has just completed a 10 year term as director of orthopaedic surgery, Kansas City General Hospital, and is now one of the senior consultants on orthopaedic surgery there. He is also an associate professor of surgery, Kansas University Medical Center.



Garrett Pipkin, M.D.

A member of the College of Surgeons, Doctor Pipkin was associated with J. Duffy Hancock, M.D., Louisville, with the 110th Evac. Hospital, 3rd Army, during World War II. He will address the general session on Wednesday, September 20, on "Fat Embolism."

A graduate of the Marquette University School of Medicine in 1939, Walter A. Ricker, M.D., Seattle, Wash., will be the guest of the Kentucky Society of Pathologists. His topic at the general session on Wednesday afternoon, September 20, will be "Laboratory Diagnosis of Infectious Mononucleosis". Doctor Ricker, a native of Minnesota, is clinical associate professor of pathology, University of Washington, School of Medicine.



Walter A. Ricker, M.D.

He is a member of the American Society of Clinical Pathologists, the College of American Pathologists, and is board certified by the American Board of Pathology, Pathologic Anatomy and Clinical Pathology. Doctor Ricker is a well known authority in the field of morphological hematology.

A native Kentuckian, Virgil A. Plessinger, M.D., is scheduled to be guest speaker for the Kentucky Chapter, American College of Chest Physicians. "Medical Aspects of Chest Trauma" is the topic which Doctor Plessinger will present at the Wednesday morning, September 20 general session. He will also participate in a panel discussion that morning.



Virgil A. Plessinger, M.D.

Doctor Plessinger is associate clinical professor of medicine, University of Cincinnati, College of Medicine; medical director, Dunham Hospital; and head of the department of tuberculosis, Cincinnati General Hospital. A graduate of the University of Cincinnati College of Medicine in 1935, he was certified by the American Board of Internal Medicine in 1947.

Medical Practitioners of five years' standing are eligible for generous residency training stipends in Psychiatry (through National Institute for Mental Health) ranging up to $12,000 a year for three years, beginning July 1963. For more information please contact S. Spafford Ackerly, M.D., Department of Psychiatry, University of Louisville School of Medicine, 206 East Chestnut, Louisville 2, Kentucky.

Committee on Scientific Assembly Releases First Draft of Program for 1961 Annual Meeting on September 19, 20, 21

The first draft of the 1961 KSMA Annual Meeting program has been released by Richard G. Elliott, M.D., Lexington, KSMA president and chairman of the KSMA Committee on Scientific Assembly and Arrangements. The program committee is headed by Frank M. Gaines, M.D., Louisville. The meeting will be held in Louisville on September 19, 20 and 21. Following is the tentative program.

Tuesday, September 19

8:45 Opening Ceremonies
9:00 "Obstetrical Emergencies"
Conrad G. Collins, M.D., New Orleans, La.
9:20 "Unusual Patterns in Common Pulmonary Disease"
Jerome F. Wiot, M.D., Cincinnati, Ohio
9:40 President's Address
Richard G. Elliott, M.D., Lexington
10:00 Visit Exhibits
10:30 "Volatile Anesthetics and Drugs Used in Mental Illness"
John C. Krants, Jr., Ph.D., Baltimore, Md.
10:50 "Hyperkinetic Behavior Disorders in Children"
William Langford, M.D., New York City
11:10 Panel Discussion
Kenneth Crawford, M.D., Louisville, moderator
Frederick A. Horner, M.D., Lexington
William Langford, M.D., New York
Lovick Miller, Ph.D., Louisville
Joseph Parker, M.D., Lexington
Luncheon
2:00 Meetings of Specialty Groups
Kentucky Anesthesiology Society—First Christian Church
Kentucky Obstetrical and Gynecological Society—First Christian Church
Kentucky Orthopaedic Society—to be decided
Kentucky Chapter, American Academy of Pediatrics—First Christian Church
Kentucky Chapter, American College of Surgeons—First Christian Church
Joint meeting, Kentucky Chapter, American College of Chest Physicians—and Kentucky Radiological Society—Columbia Auditorium

Wednesday, September 20

9:00 "Abdominal Injuries"
Charles G. Child, M.D., Ann Arbor, Mich.
9:20 "Fat Embolism"
Garrett Pipkin, M.D., Kansas City, Mo.
9:40 "Emergency Airways"
Lt. Col. George F. Rumer, Fort Sam Houston, Tex.
10:00 Visit Exhibits
10:30 "Medical Aspects of Chest Trauma"
Virgil A. Plessinger, M.D., Cincinnati, Ohio
10:50 Panel Discussion
Alston Callahan, M.D., Birmingham, Ala.
Garrett Pipkin, M.D., Kansas City, Mo.
Virgil Plessinger, M.D., Cincinnati, Ohio
Jerome Wiot, M.D., Cincinnati, Ohio
Charles G. Child, M.D., Ann Arbor, Mich., moderator
11:50 President's Luncheon
2:00 "Favus"
A. B. Loveman, M.D., Louisville
Emil Kotcher, Ph.D.
2:20 "Peciodontia"
Pat H. Lyddan, D.M.D., Louisville
2:40 "Sight Saving Measures"
Alston Callahan, M.D., Birmingham, Ala.
3:00 Visit Exhibits
3:30 "Laboratory Diagnosis of Infectious Mononucleosis"
Walter Ricker, M.D., Seattle, Wash.
3:50 "External Cardiac Massage"—scientific film

Thursday, September 21

9:00 Specialty Group Meetings
Kentucky EENT Society—First Christian Church
Ky. Chapt., American Academy General Practice—Columbia Auditorium
Kentucky Society of Pathologists—First Christian Church
Ky Chapt., American College of Physicians—First Unitarian Church
Kentucky Psychiatric Association—First Christain Church
Kentucky Public Health Association—First Christian Church
Luncheon
2:00 "Hypnosis in Medical Practice"
Louis J. West, M.D., Oklahoma City, Okla.
2:20 "Nutrition in Surgery"
James Barron, M.D., Detroit, Mich.
2:40 "Gout"
Brig. Gen. Robert E. Blount, Washington, D.C.
3:00 Visit Exhibits
3:30 Panel
Frank Princi, M.D., Cincinnati
Richard Greathouse, M.D., Louisville
Arthur Shulthise, M.D., Louisville

Six at U. of L. Receive Grants From Heart Association

The American Heart Association has awarded two new medical research grants and has renewed two others to the University of Louisville School of Medicine.

The two new grants are: $10,395 to Robert S. Levy, M.D., to study the action of an enzyme believed to play an important role in preventing hardening of the arteries; and $6,050 to Peter K. Knoefel, M.D., and K. C. Huang, M.D., for studies of kidney function, particularly the way organic acids and other materials are transported across cell walls.

Renewed grants are: $3,300 to Beverly T. Towery, M.D., and William A. Brodsky, M.D., to continue their work on the use and elimination of salts in the system; and $5,500 to Sheppard M. Walker, M.D., to renew his investigations on the physiology of the heart muscle.

Rural Scholarship Fund Awards 20 New $1,000 Loans

The Board of Trustees of the Rural Kentucky Medical Scholarship Fund at its annual meeting May 4 in Louisville unanimously approved the award of 20 new $1,000 loans to medical students.

Recipients of the scholarships, repayable over a long term at two per cent interest, are required to practice in a rural Kentucky county one year for every year they are awarded a scholarship. They may practice anywhere in Kentucky with the exception of six counties and eight cities which are considered adequately supplied with doctors.

However, the board often encourages recipients to practice in one of the ten counties on its critical list where shortage of physicians is severe. These counties are: Breathitt, Elliott, Jackson, Knott, Wolfe, Magoffin, Leslie, Martin, Owsley and Powell. Wolfe County has replaced Knox County on the critical list.

The fourteen freshman receiving scholarships are: Robert B. Elliott, Morganfield; David C. Hadden, Louisville; William E. Jackson, Bardwell; Linda E. Sandlow, Barbourville; and Frank Whalen, Jr., Paris, all to go to the University of Louisville School of Medicine.

Freshmen to attend the University of Kentucky Medical School are: Benjamin S. Bell and Harry R. Bell, brothers from Elkton; Kelly G. Moss, Glasgow; Jimmy Don Robinson, Kevil; William H. Wagner, Jr., Middlesboro; Raymond D. Wells, Lancer; and Bryon Young, Somerset.

Gerald Owen Daniel, Hartford, will go to the Bowman Gray School of Medicine, Winston-Salem, N. C., and Henry Earl Jones, Benton, will attend Tulane University School of Medicine. They are also freshmen.

Four sophomores have received first scholarships from the fund. They are: Brown L. Adkins, Sandy Hook; Paul R. Lewis, Olive Hill; and John Lynn Shanton, Lebanon, all at the University of Louisville. William E. Morris, Jr., Paducah, is attending St. Louis University School of Medicine.

There are two juniors receiving awards: Elster D. Roberts, Lexington, and James F. Rold, Owensboro, both of U. of L.

Other action taken by the board was the approval of 38 second, third and fourth loans of $900 each to Kentucky sophomore, junior, and senior medical students. The trustees also moved to grant second, third and fourth loans of $900 each to an additional 18 medical students if and when they are requested.

Another motion was passed to request $20,000 additional from the State over a two-year period starting July, 1962. This would bring the yearly appropriation from the government to $35,000 a year.

Elections were held after the awards were made. All officers were re-elected and three new members were elected to the board. They are: Meredith Cox, Richmond; Leon Higdon, M.D., Paducah; and Claude E. Cummins, M.D., Maysville.

The following board members were re-elected: Cass Walden, Edmonton; G. Y. Graves, M.D., Bowling Green; Russell E. Teague, M.D., Frankfort; George D. Caldwell, Louisville; Delmas M. Clardy, M.D., Hopkinsville; and Mark V. Marlow, Lexington.



The president of KSMA, Richard G. Elliott, M.D., Lexington, turns the first spade of dirt for the new building as Lt. Governor Wilson Wyatt, featured speaker at the ground-breaking ceremonies, and George F. Brockman, M.D., Greenville, chairman of the Building Committee, look on. Ceremonies were held Sunday, May 21.

Ground Breaking Ceremonies Held for New KSMA Headquarters

Members of the KSMA Board of Trustees and guests heard Lt. Governor Wilson Wyatt give the principal address at ground breaking ceremonies for the Association's new headquarters office on Sunday, May 21.

Richard G. Elliott, Jr., M.D., Lexington, KSMA president broke the first spadeful of ground at the ceremony.

In his talk Lt. Gov. Wyatt lauded the Association for its 110 years of service to Kentuckians, noting that the new building was symbolic of the KSMA's intention to continue its fine tradition of service. A summary of his talk will be carried in the July issue of The Journal of KSMA.

Located on the northwest quadrant of the Watterson Expressway and Taylorsville Road interchange at the corner of Abigail and Janet avenues, the new headquarters will be a one story brick building of contemporary design. Encompassing more than 6,000 square feet of space, it will be divided into two parts —administrative and executive. The executive wing



This is the architect's idea of how the new KSMA headquarters building will look upon completion. It faces the Watterson Expressway in the northwest quadrant of its intersection with Taylorsville Road. Construction on the new building has been started. Completion of the structure should take place by the end of the year.



Chairman of the Board of Trustees, James M. Stevenson, M.D., Brooksville, turns a spade of dirt at the new headquarters building site as George F. Brockman, M.D., Greenville, holds his hat.



Members of the Building Committee were called on to do their part with the spade. They are, from left to right, Hoyt D. Gardner, M.D., Louisville; N. Louis Bosworth, M.D., Lexington; and George F. Brockman, M.D., Greenville, chairman of the committee.

will include a board room, president's office, and committee rooms. The administrative section will include offices for the staff and storage space.

Architects are Niven and Morgan and contractor is Fred J. Lichtenfield and Son, both of Louisville. Plans call for completion of the building in approximately seven months.

Seventh District Meeting Held June 8 at Frankfort

Wyatt Norvell, M.D., New Castle, reports that the annual meeting of the Seventh Trustee District, June 8 at the Frankfort Country Club had three members of the University of Louisville School of Medicine as scientific essayists.

Speakers and their subjects were: Elliott Podoll, M.D., who discussed "Immunization-Modern Attitudes;" Maurice A. Perellis, M.D., who talked on "Summer Pediatric Problems;" and William W. Johnson, M.D., who presented a paper on "Pediatric Surgery."

Physicians from the following ten counties attended: Anderson, Carroll, Gallatin, Grant, Franklin, Henry, Oldham, Owen, Shelby, and Trimble.

Class Reunions To Be Held in September

The following classes of the University of Louisville will hold Alumni Reunions September 19-21 in conjunction with the KSMA Annual Meeting: 1911, 1921, 1926, 1931, 1936, 1941, 1946, 1951, 1956.

Members of the class of 1911 will be guests of honor and will receive their 50-year buttons. Chairmen for this group are Oscar Miller, M.D., Louisville, and C. C. Howard, M.D., Glasgow.

Chairmen for the 1956 class, youngest group to hold a reunion this year, are William P. VonderHaar, M.D., and Henry Jackson, M.D., both of Louisville.

Class luncheons and dinners will fill in the program which will be announced later.

Second Year Curriculum Approved by U of K

The second year curriculum for the University of Kentucky College of Medicine has been approved by the University faculty. Like the curriculum for the first year, the second year courses have been planned with emphasis on the essential relationships and developments of each course to that which preceded it, to those conducted simultaneously, and to those which follow.

The second year curriculum is composed of the following course units:

Com. Med. 221	Community Medicine
Conjoint 221	Fundamentals of Microbiology and Infectious Diseases
Conjoint 222	Parasitic Diseases of Man
Conjoint 223	Physiology and Biochemistry of Drug Action
Medicine 221	Medical Diagnosis
Psychiatry 221	Psychopathology of Behavior
Radiology 021	Radiobiology
Pathology 421	Fundamental Human Pathology
Pathology 422	Systematic Human Pathology
Pathology 423	Case Studies in Disease
Behav. Sci. 422	Biological Statistics

The Department of Physiology, Loren D. Carlson, Ph. D., chairman, has received approval from the University faculty for establishment of its proposed graduate program leading to the Masters of Science and Doctor of Philosphy degrees. The new proposal is designed to cope with the problems which have frequently led to either lengthening doctoral programs or restricting program scope.

The University has announced a number of new appointments including that of Rudolph J. Muelling, Jr., M.D., as professor of pathology and head of the section of Forensic Pathology and Toxicology, Department of Pathology. The announcement also included the appointments of five other assistant professors and instructors.

The rosters for the departments of anatomy, physiology, and behavioral science and appointments in the new College of Dentistry have been announced.

The College of Nursing will offer the third in a series of Nursing Service Workshops on June 22-23. The latest will be a "workshop on the counseling interview." Visiting lecturer will be Genevieve Burton, Ed. D., the University of Pennsylvania School of Medicine and School of Nursing.

Plastic Surgery Society Elects New Officers at Louisville

The Ohio Valley Plastic Surgery Society held its annual meeting in Louisville, May 4-7. Sixty-two people attended, including 42 active members, their wives and guests.

Members attended scientific sessions on Friday, the Derby on Saturday and a business meeting and elections on Sunday morning. Clyde Litton, M.D., Charleston, W. Va., was installed as president and the following new officers were elected: president-elect—J. C. Gaisford, M.D., Pittsburgh, Pa.; vice-president—J. C. Kelleher, M.D., Toledo; and secretary-treasurer—John Tondra, M.D., Indianapolis.

The next meeting of the society will be held May 1962 at the Hotel Greenbriar, White Sulphur Springs.

KAGP Elects Dr. Williams; Installs Dr. Morgan

J. Sankey Williams, M.D., Nicholasville, was chosen president-elect of the Kentucky Academy of General Practice as Edward B. Morgan, M.D., Louisville, was installed as president at the annual meeting of the KAGP in Louisville, May 10-13. Doctor Williams is KSMA's Legislative Key Man for Jessamine County.



J. Sankey Williams, M.D.

A total of 758 members and guests and exhibitors attended the meeting as Doctor Morgan succeeded John G. Archer, M.D., Prestonsburg, as president.

Floyd C. Bratt, M.D., president of the American Academy of General Practice, was guest speaker at the annual dinner. His topic was "This is Our Responsibility."

Chosen "Citizen Doctor of the Year" was Thomas O. Meredith, M.D., Harrodsburg. Doctor Meredith is Trustee of the KSMA 12th District, a member of the Board of Directors and past president of Kentucky Physicians Mutual which is the Blue Shield Plan for Kentucky.

Other awards included a plaque as scientific award for the best paper published in a scientific journal to Clarence O. Dixon, Jr., M.D., Louisville. His paper was "A Second Look at Obesity" published in the KAGP Journal in January 1961. George Allen, M.D., Louisville, received a pendant for his original plaque for a scientific article. His paper, published in Chemical Medicine, May 1960, was "Test of Pregnancy."

Plaques for outstanding service went to: Robert Sirkle, M.D., Lexington, for outstanding services as chairman of the scientific committee; Doctor Archer for outstanding service as president during the past fiscal year; and Doctor Williams for outstanding service above and beyond the call of duty as executive secretary of the Academy. A letter of commendation was given Carroll L. Witten, M.D., Louisville, for outstanding services to the Academy in the past and particularly the noteworthy honor brought to the KAGP as Speaker of the Congress of Delegates of the AAGP at its recent meeting in Miami.

Other new officers elected are: vice presidents of KAGP's four state regions—Robert L. Sumner, M.D., Henderson; James W. Davis, M.D., Louisville; Carl Cooper, Jr., M.D., Bedford, and Charles B. Johnson, M.D., Russell. The treasurer will be Roy G. Wilson, M.D., Campbellsville, and the office of secretary will be held by Doctor Sirkle. The one new director elected was Charles W. Sisk, M.D., Danville, who replaces John M. Baird, M.D., also of Danville. New speaker of the Congress of Delegates is Patrick J. Murphy, M.D., Lebanon Junction.

Dr. Glen Spurling Honored May 20 by Associates at U of L

May 20 was "Glen Spurling Day" at the University of Louisville in honor of Doctor Spurling, a member of the faculty for 35 years and head of the section of neurosurgery since its inception.



Glen Spurling, M.D.

Internationally known as outstanding in his field, Doctor Spurling will retire from administrative duties as head of the neurosurgical section at the end of the academic year. He will continue in private practice and will teach at the university as Distinguished Professor of Neurosurgery.

"Glen Spurling—the Man" was the theme of an awards banquet that night at the Brown Hotel following a day of scientific presentations by seven nationally known neurosurgeons and four presentations by U. of L. faculty members. Special recognitions and awards were given to Doctor Spurling by Major Thomas Hartford, M.C., U.S.A., Acting Surgeon General who conferred upon him the Meritorious Civilian Service Award which is the top honor within the purvue of the Surgeon General; J. Murray Kinsman, M.D., dean of the School of Medicine, who announced the Distinguished Professorship; and Philip Davidson, president of the University of Louisville, who read a citation adopted by the Board of Trustees of the University.

Skits on the "Spurling—the Man" theme covering all phases of Doctor Spurling's life from residency to the present were given at the banquet. E. A. Osius, M.D., Detroit, was toastmaster. The program was planned by Rudolf J. Noer, M.D., professor and chairman of the department of surgery.

Distinguished visitors presenting scientific papers included: Maj. Gen. Thomas J. Hartford, M.D., U. S. Army; Frank H. Mayfield, M.D., University of Cincinnati; Kenneth G. McKenzie, M.D., University of Toronto; R. Eustace Semmes, M.D., University of Tennessee; Arthur A. Ward, M.D., University of Washington; and Barnes Woodhall, M.D., Duke University School of Medicine.

Members of the University of Louisville Medical School faculty giving talks during the morning session were: S. Spafford Ackerly, M.D.; Joseph Keith, Jr., M.D.; William N. Keller, M.D.; Edward E. Landis, M.D.; Ephraim Roseman, M.D.; and Doctor Spurling. The scientific portion of the program was held at the Rankin Amphitheater of the Louisville General Hospital.

Participants in the skit on Doctor Spurling's life included: Doctor Bailey, Doctor Keller, Doctor Mayfield, Doctor Semmes, Doctor McKenzie, Doctor Woodhall, and Arnold Griswold, M.D.

Doctor Spurling gained nationwide attention as Neurosurgical Consultant to the Surgeon General and later became Senior Neurosurgical Consultant to the European Theater of Operations. He also gained nationwide attention when he was flown back to Europe as a consultant when General George Patton received his fatal injuries.

Postgraduate Offerings for Area Listed Through September

The Postgraduate Medical Education Office announces that a one day course in Medicine is tentatively planned to be held in Harrodsburg on July 13. It has been submitted for Category I Credit from the American Academy of General Practice.

Another program is a course being offered at the University of Kentucky Medical Center, Lexington, on Chest Diseases September 13 and 14. A one day course in Pulmonary Disease was held at the Kentucky Hotel, Louisville, June 15. These courses have also been submitted for Category I Credit from the American Academy of General Practice.

Detailed information may be obtained from the Postgraduate Medical Education Office, 104 West Chestnut Street, Louisville 2, Ky. The telephone number is JUniper 7-7135.

The complete listing follows:

June

Weekly through 1961	One week training in the field of OB-GYN, each week during 1961, with the exception of October 2-7, and October 23-28, limitation of two physicians per week; fee of $50 includes room at General Hospital, if desired, 42 hours of Category I Credit granted by the AAGP. Enrollment should be made at least two weeks before desired participation.
15	Postgraduate course, "Pulmonary Disease," Kentucky Hotel, Room #317, Louisville.
22	Kentucky Academy of General Practice Seminar; Henderson, Robert Sumner, M.D., Henderson, Chairman.
22	Fourth and Sixth Trustee District Meeting, State TB Hospital, Glasgow.
26-30	AMA Annual Meeting, New York City.

July

6	KAGP Seminar; Paintsville; George P. Archer, M.D., and James W. Archer, M.D., co-chairmen.
13	Postgraduate course, "Medicine," Harrodsburg, (Tentative).

August

16	KAGP Seminar; Cumberland Falls; E. C. Seeley, M.D., London, chairman.
20	KAGP Seminar; Lexington, Ky.

September

13	Postgraduate course, "Chest Diseases," University of Kentucky Medical Center, Lexington, Ky.
19-21	Annual Kentucky State Medical Association Meeting, Louisville.

Kentucky Surgical Society Elects Dr. Sparks

Clyde Sparks, M.D., Ashland, a former president of KSMA, was elected president of the Kentucky Surgical society at its annual meeting May 13 at French Lick, Ind. He succeeds J. Duffy Hancock, M.D., Louisville, also a former KSMA president.



Clyde C. Sparks, M.D.

David Kinnaird, M.D., Louisville, was elected vice president, and C. Melvin Bernhardt, M.D., Louisville, began the last of a three-year term as secretary - treasurer. The new chairman of the Council is Hart. H. Hagan, M.D., Louisville. Other members of the Council are Branham B. Baughman, M.D., Frankfort, and Doctor Hancock.

The scientific program was presented by the Department of Surgery of the University of Louisville School of Medicine. Rudolf J. Noer, M.D., professor and chairman of the department, served as program chairman for the meeting. Sixteen papers were presented during the program by members of the faculty of the Department of Surgery.

There were 125 members and their guests present. The Society, which limits its membership to 125, elected five new members to bring it to that number. New members are: Hugh Mahaffey, M.D., Richmond; Harold B. Barton, M.D., Corbin; Hoyt D. Gardner, M.D., and Robert C. Tate, M.D., both of Louisville; and Burton A. Washburn, M.D., Paducah.

The 1962 meeting of the Society will be held in Cincinnati and the Department of Surgery of the University of Cincinnati School of Medicine will participate in the program.

California MD's, DO's Sign Unification Agreement

Merger of the California Medical Association and the California Osteopathic Association took the first of its last three steps when a unification agreement was signed in March by Doctor Paul D. Foster, CMA president and Doctor Dorothy Marsh, COA president. Next the agreement goes to the members of the Houses of Delegates of the CMA and the COA.

"Prime objectives of the merger of the two professions," said the two presidents in a joint statement, "is to improve the health services available to the citizens of California and to expand present medical teaching facilities."

Under the agreement the Los Angeles College of Osteopathic Physicians and Surgeons will be converted into a medical school and properly licensed osteopathic physicians who receive a Doctor of Medicine degree may elect to use either the suffix "M.D." or "D.O.", but may not use both.

UL Seniors Hold Meeting

The annual meeting for senior medical students of the University of Louisville was held at the Blue Cross-Blue Shield building, Louisville, on April 21. Hoyt Gardner, M.D., Louisville, was moderator for the program and H. Hart Hagan, M.D., and Sam A. Overstreet, M.D., both of Louisville, were speakers. The program also included a tour of the building with explanations of over-all and departmental operations.

Zimmerman Succeeds Gatton As Ky. CC Staff Chief

Harper Gatton, Madisonville, executive vice president of the Kentucky Chamber of Commerce since 1952, left that post April 30 after many years of civic and public service. He will be succeeded by James C. Zimmerman, Middletown, previously assistant executive vice president, who has been a member of the staff of the Chamber since 1955. He had also served as Director of Industrial Development.



Harper Gatton

Mr. Gatton, a native Kentuckian, was superintendent of Madisonville schools from 1914 to 1953; chairman of the Kentucky Textbook Commission, 1928 to 1936; president of the Kentucky Education Association, 1933; president of the Madisonville Chamber of Commerce, 1949-53; and vice-president of the Kentucky Chamber of Commerce, 1950-52.

A native of Arkansas, Mr. Zimmerman has been president of the Henderson Chamber of Commerce. He is now secretary of the executive committee of Kentucky Spindletop Research Center, Inc.; a member of the Southern States Industrial Council; the American Industrial Development Council; and is on the exceutive committee of the Southern States Community Development Association. He has also served as a member of the Governor's Advisory Committee on the sales tax and coordinates the activities of Kentucky's "Industrial Team," made up of professional plant location experts.



James Zimmerman

The Board of Directors of the Kentucky Chamber of Commerce has also elected Smith D. Broadbent, Jr., Cadiz, as president. Mr. Broadbent, a western Kentucky agriculture leader, served for 11 years as chairman of the Kentucky State Fair Board. He has also been chairman of the Kentucky Agriculture Council, is a member of the National Tobacco Research Council of the USDA, and is a trustee of Methodist Hospital, Henderson.

Digest of the Meeting of the Board of Trustees

The KSMA Board of Trustees met at the Phoenix Hotel, Lexington, in an eight-hour meeting, April 5, the evening preceding the 1961 County Society Officers Conference.

Following a discussion, the 1961-62 budget was accepted by the Board as presented by the Budget Committee and recommended by the Executive Council.

"Go ahead" approval was given to the Building Committee after a detailed analysis and report by the Building Chairman, George Brockman, M.D., Greenville.

Gaithel Simpson, M.D., Greenville, KSMA President-elect, reported to the Board on a legislative conference that had been held in Chicago on March 18 and 19. Following this report, the Board recommended that the KSMA Headquarters staff devote more of its time to legislative matters.

By increasing its membership to over 2,000 AMA members, the KSMA qualified for a third delegate and alternate. The Board accepted the recommendation of the Executive Committee in naming Doctor Brockman as delegate and John Quertermous, M.D., Murray, as alternate.

A report on the activity of the KSMA Technical Advisory Committee to the Governor's Advisory Council on Indigent Care was made by the chairman, Clyde Sparks, M.D., Ashland. After a lengthy discussion by the Board and guests, it was recommended that the KSMA support in full the provision of the Kerr-Mills bill.

Confirmed as members of the newly formed Highway Safety Committee were Doctors Keeney, chairman, Arnold Griswold, William Keller, all of Louisville, Delmas M. Clardy, Hopkinsville and Timothy Swartz, Lexington. Also approved was the request of the Public Health Department on holding Well Child Conferences throughout the state, subject to the approval of each County Board of Health.

Nominations were submitted to the Governor for the vacancy existing on the State Health Board. After listening to a presentation by U. S. Treasury Agents, the Board adopted a resolution opposing non-ambulatory treatment of narcotic addicts.

The Board heard an appeal by a UMWA representative in Pike County who wanted the Board to arbitrate the differences between the members of the Pike County Medical Society and the UMWA physicians. Following the hearing and discussion, the KSMA attorney was authorized to inform the UMWA physicians that the Board had no authority to dictate policy to the Pike County Medical Society due to its autonomy.

Other actions included the tabling of a recent request concerning the licensing of foreign medical graduates. Instruction was given the KSMA legal counsel to inform the Greater Cincinnati Radiological Society that it is the Board's opinion that it is not ethical for a physician to be employed by a hospital since a hospital (or any corporation) cannot practice medicine in Kentucky, and that the physician's position ultimately becomes unethical, under Section 4 of the "Principles of Ethics."

BLUE SHIELD of Kentucky
NEWSLETTER

Vol. 1 MAY 1961

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BLUE SHIELD HOME OFFICE

As a result of the recommendation of the KSMA Advisory Committee to the Kentucky Blue Shield Plan, a quarterly Newsletter will be issued by the Blue Shield Plan of Kentucky to al Kentucky physicians. The above is a copy of the first page of the first issue. The committee urges all KSMA members to be on the lookout for and read each issue.

D. D. Turner, M.D., London, was chosen outstanding citizen of Laurel County by the London Jaycees at a civic night program in April. Doctor Turner was cited for his participation in many activities; particularly in recreation.



Colonel Lucius G. Thomas, M.D., left, a 1933 graduate of the University of Louisville School of Medicine, is now chief of the Preventive Medicine Division, Office of the Army Surgeon, Fort George G. Meade, Md. Here he receives the "A" prefix to his military occupational specialty number for professional achievement in the field of preventive medicine from Colonel L. F. Wilson, right, Second Army Surgeon.

Available only to physicians for their distribution—

Complete Cholesterol Depressant Menus and Recipe Book

A new, authoritative patient-aid . . . for professional distribution only

Now available for use in your practice from The Wesson People . . . easy-to-use manual of 40 pages, including all necessary diet instructions . . . menus, recipes, shopping and cooking guidance . . . all worked out for you . . . so arranged and printed that you have only to check the desired daily calorie level before giving the book to your patient.

You will find this book invaluable for treating patients with elevated serum cholesterol.

Complete menus for 10 days enable you to prescribe diets which are appetizing, nutritiously adequate and which can exert cholesterol depressant activity. Special attention has been given to constructing the menu patterns so that they adhere as closely as permissible to the patient's normal eating habits.

NRC Standards fulfilled. Each menu has been calculated to provide the proper daily allowance of proteins, vitamins and other nutrients as recommended by the Food and Nutrition Board of the National Research Council.

Weight control is achieved as each day's menu is given at 3 calorie levels—1200, 1800 and 2600 calories. You prescribe the level most desirable and modify as desired.

Variety and appetite appeal for patient are built into the menu plan to an extent not previously accomplished. Alternate choices for main dishes minimize monotony, encourage the patient to follow closely the menu plan you specify.

Complete recipes—65 in all—are included to assure that the specified menus provide prescribed levels of calories, the pre-determined ratio of poly-unsaturated to saturated fat, plus essential nutrients.

Dietary fat is controlled so that approximately 36% of the total calories are derived from fat and at least 40% of these fat calories are from poly-unsaturated components (linoleates) as found in pure vegetable oil. The replacement of saturated dietary fat by this percentage of poly-unsaturated fat has been found in clinical studies most effective in the reduction of serum cholesterol and in its maintenance at desirable levels. More liberal menus are provided for maintenance after the patient's progress indicates that desired therapeutic results have been accomplished.

Family meal preparation is simplified. The menus are planned around favorite foods having wide appetite appeal for all members of the household. Patients can entertain in comfort—enjoy cakes, cookies, snacks, prepared with recipes which meet medical requirements.

A high degree of satiety is achieved even at the lower calorie levels, because Wesson provides an unexcelled source of concentrated, slow-burning food energy.

Adaptable for use with diabetics. Carbohydrates have been calculated to fall within the acceptable range for patients to whom a diet planned for diabetes is important. Calories, which must be supplied from fat when the carbohydrate intake is limited, are provided by desirable poly-unsaturated vegetable oil.

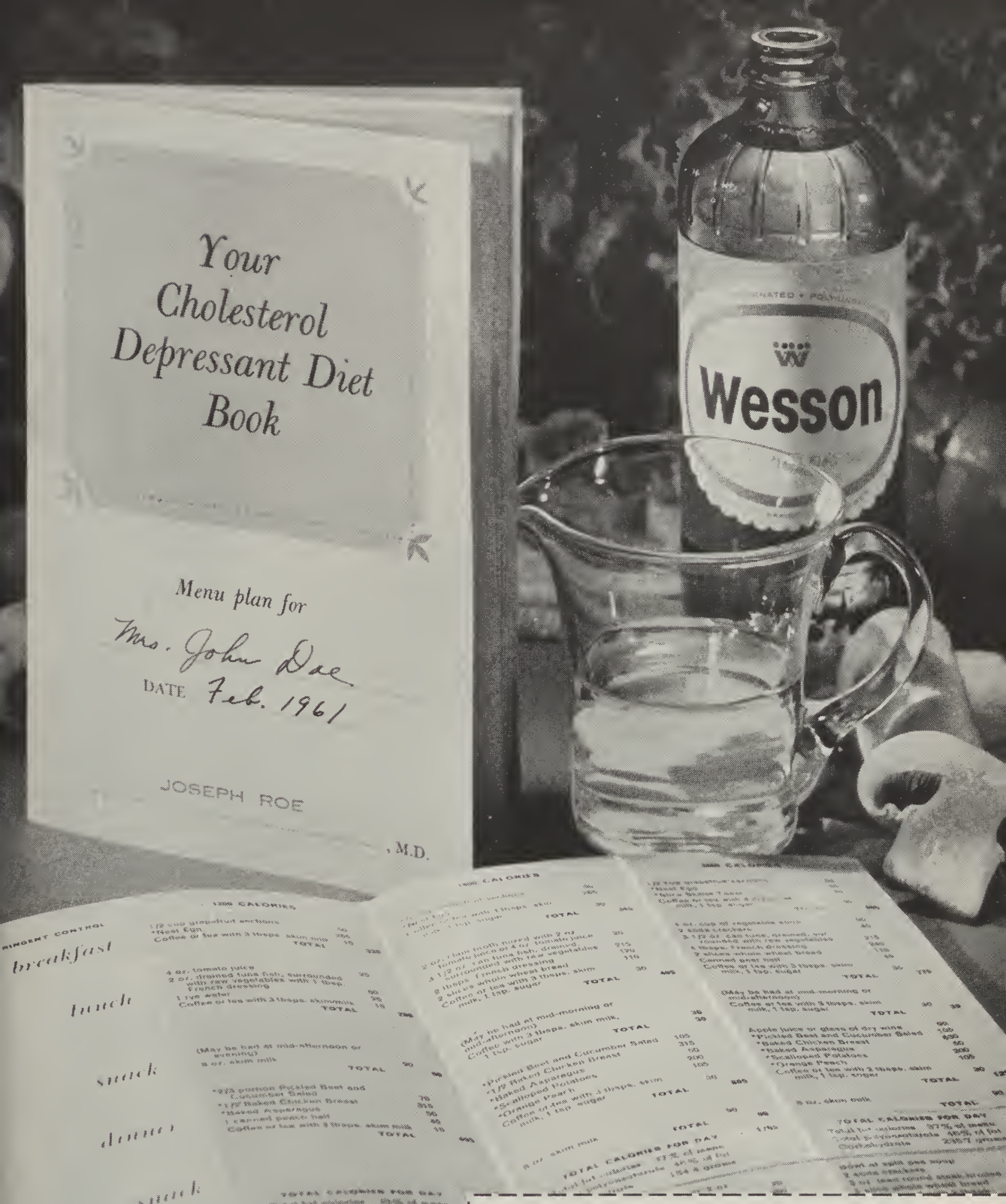
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Phytosterol (Predominantly beta sitosterol)	0.3-0.5%
Total tocopherols	0.09-0.12%

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Poly-unsaturated Wesson is unsurpassed by any readily available brand, where a vegetable (salad) oil is medically recommended for a cholesterol depressant regimen.



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Diabetes Symposium Held

A one-day symposium on diabetes attended by 40 general practitioners, pediatricians, and surgeons, was held at Red Cross Hospital, Louisville on May 17.

Nine experts spoke on various aspects of the ailment. They included: Lester Henry, M.D., assistant dean of the Howard University School of Medicine, William Golden Davis, D.M.D., Louisville, Paul Mandelstam, M.D., assistant professor of medicine, University of Kentucky Medical School. Members of the faculty of the University of Louisville School of Medicine who spoke included J. Alex Haller, Jr., M.D., assistant professor of surgery, and Roderick MacDonald, M.D., assistant professor of ophthalmology.



J. Alex Haller, Jr., M.D., surgeon and member of the "Heart Team" of General and Children's Hospitals, Louisville, was guest speaker on "Heart Surgery" at a training conference held for Blue Cross-Blue Shield staff members March 29 in Louisville. The training conference was part of a program to acquaint all Blue Cross-Blue Shield personnel with advances in medical science and technology and how they affect health care costs.

Health Board Appointments Made

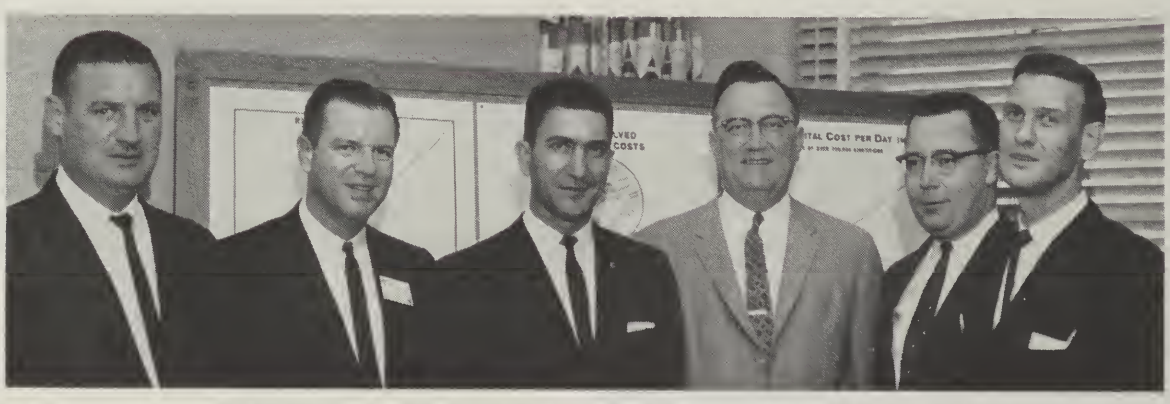
Announcement has been made by the office of Governor Bert Combs that Robert W. Robertson, M.D., Paducah, has been appointed to succeed himself for a four year term as a member of the Kentucky State Board of Health. Branham B. Baughman, M.D., Frankfort, has been appointed to a four-year term to succeed Thomas P. Leonard, M.D., Frankfort, whose term expired.

Doctor Robertson is a recent past president of the Association and Doctor Baughman is a former chairman of the KSMA Council, now known as the Board of Trustees. Both are members of the Board of Directors of Kentucky Physicians Mutual.

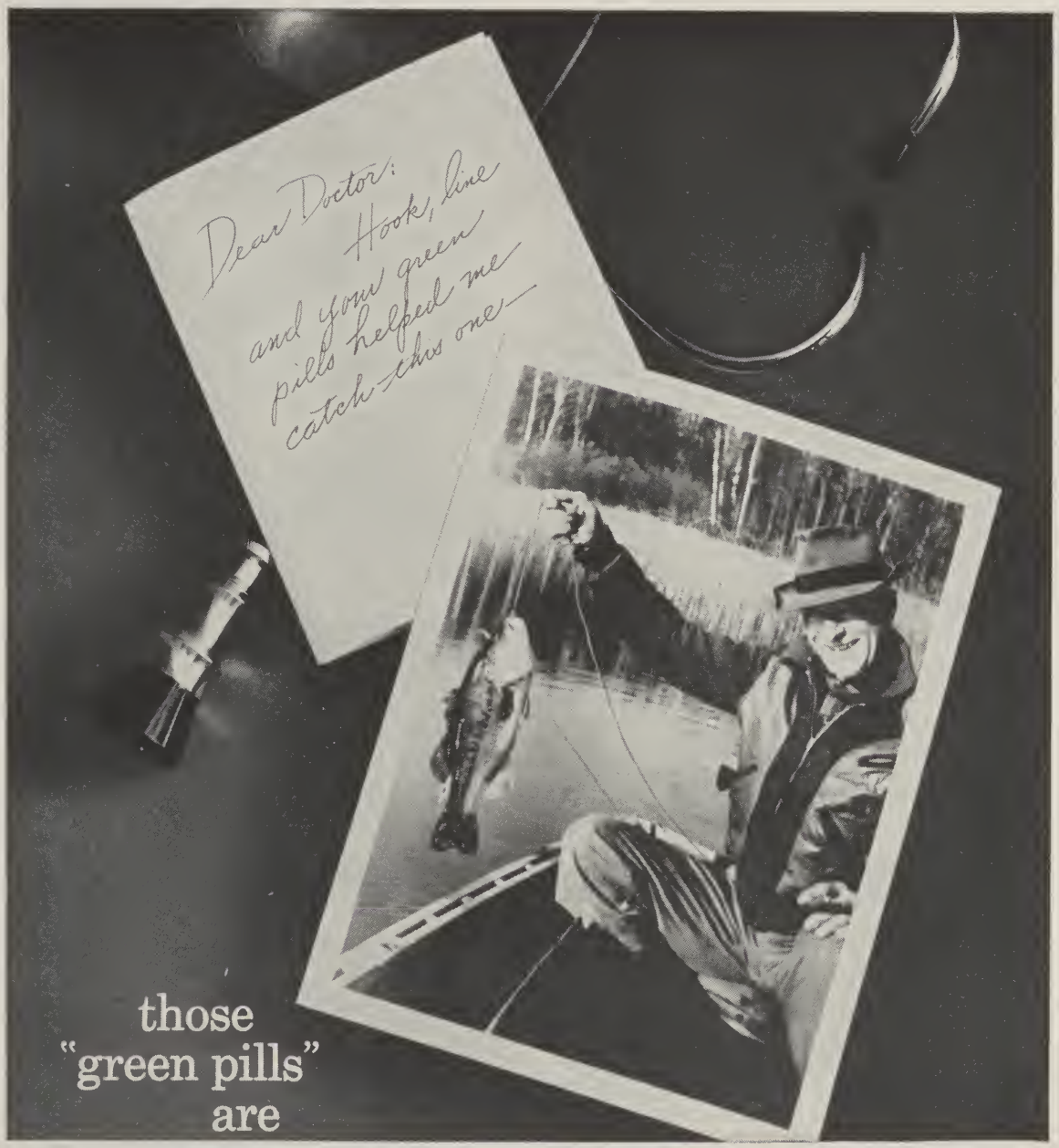
KSMA New Members Listed

KSMA has added 20 new members since The Journal's last report. They are:

Robert C. Burkhart, M.D., Harlan
William D. Bushong, M.D., Owensboro
R. Glenn Greene, M.D., Owensboro
Herbert P. Hargett, M.D., Louisville
Thomas L. Heavern, Jr., M.D., Newport
Richard Holt, M.D., Franklin
Thomas C. Lane, M.D., Fulton
F. R. Larsen, M.D., Earlington
Jesse Page, M.D., Mayfield
David W. Scott, M.D., Louisville
Edward F. Slothour, M.D., Red Bird
W. B. Stewart, M.D., Lexington
Elvis R. Thompson, M.D., Stone
Marguerite E. Thompson, M.D., Stone
Richard C. Turrell, M.D., Louisville
D. N. Tweeddale, M.D., Madisonville
James L. Wagstaff, M.D., Fort Thomas
W. O. West, M.D., Lexington
William G. Ward, M.D., Owensboro
J. G. Wilhite, M.D., Lexington



These are faces you will be seeing soon. Attending the Blue Cross-Blue Shield training conference were special representatives for the Hospital-Physician Service Department of Blue Cross-Blue Shield are, left to right, William Moore, Bowling Green, who will serve South Central and Southeastern Kentucky; David Greenwell, Louisville, whose service area is Greater Louisville and North Central Kentucky; Avil McKinney, director, Hospital-Physician Service Dept.; Lester Kesler, Paducah, to service Western Kentucky; Willard Chapman, Ashland, servicing Eastern Kentucky; and James Franklin, Lexington, who will service Greater Lexington and the Bluegrass area.



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Student AMA

National SAMA Convention Report

The eleventh annual convention of the Student AMA opened Thursday morning, May 4, with the seating of the House of Delegates. The University of Louisville was among the medical schools represented, and the University of Kentucky was awarded unanimous approval of their petition for membership in the national organization, and were also seated.

The business of the House, which met in closing session Sunday morning, May 7, was concerned mainly with the problems facing medicine in our society today. Chiefly the House was concerned with social security for physicians and medical care for the aged.

The House of Delegates of the Student AMA is opposed to mandatory social security legislation for physicians and adopted a program of polling the future physicians of the U. S. as to their personal opinion of social security legislation for them.

The House also voted to go on record in support of the Kerr-Mills bill for state medical aid to the aged, and in opposition to the King-Anderson bill.

Among the more interesting aspects of the convention was a short talk by former Vice President Richard Nixon, who encouraged the members present to be interested enough in their profession to do more for it than is generally required.

Morris Fishbein, M.D., also spoke at one of the luncheon meetings on the change of medicine in this century. The convention was highlighted on Saturday night by the Abbot party, at which the seniors from the University of Louisville were special guests.

One of the most important features gained from the convention was the solidarity of thought, action, and communication which was welded between the students from the Universities of Kentucky and Louisville. It is hoped that the friendship and feeling of oneness thus born may create a trend in sharing of ideas and scientific endeavor on a greater scale, one which will eventually encompass and fulfill the needs for medicine in the Commonwealth.

Olson Huff—Delegate
Rollin S. Burhans, Jr.—Alternate Delegate

Robert W. Wallace, M.D., a 1953 graduate of Creighton University School of Medicine, Omaha, Nebraska, has begun practice in Louisville in association with Raymond Heitz, M.D., and Robert Bergner, M.D. Doctor Wallace interned at St. Joseph Mercy Hospital, Sioux City, Iowa, and took his residency at St. Francis Hospital, Wichita, Kansas. He held the rank of captain in the U. S. Air Force and had practiced in Omaha before coming to Louisville.

Rudy Vogt, M.D., Louisville, has been named chairman of the Salvation Army Home and Hospital Advisory Council. He will oversee the operation of the 36-bed hospital for unwed mothers and recruit the volunteer help of additional obstetricians. The hospital has been in operation since 1955.

Dr. Kinsman Given New Post; Dr. Gaines Resigns

J. Murray Kinsman, M.D., dean of the University of Louisville School of Medicine, has been given the additional title of director of hospital relations. He will coordinate programs of hospitals and the Medical School to ensure close cooperation.

Doctor Philip Davidson, U. of L. president, announced the appointment of Dr. Kinsman and said the university trustees have also authorized the creation of a new Medical School post—associate dean. A committee of faculty members has begun to seek candidates for the new position.

The Medical School also intends to fill the post of assistant dean and director of admissions which will become vacant July 1 with the resignation of Frank M. Gaines, M.D.

Doctor Gaines, who is chairman of the KSMA Scientific Program for the Annual Meeting, is a former Kentucky commissioner of mental health. He will return to the full-time practice of psychiatry, but will remain on the faculty as part-time professor of psychiatry.

UL Announces Faculty Changes

The University of Louisville School of Medicine announces the appointment of Kenneth F. Keller, M.D., as instructor on microbiology. The promotions of two other faculty members were also announced. Sidney Roston, M.D., has been promoted from instructor to assistant professor of medicine and Warren H. Dennis, M.D., from associate in physiology to assistant professor of biophysics in the department of physiology and from instructor to associate professor in the department of community health.

Pediatricians Elected Fellows

The American Academy of Pediatrics has elected three Louisville physicians as fellows. They are: William W. Johnson, M.D.; John Doyle, M.D.; and J. Kenneth Harris, M.D. Doctor Johnson was also elected a member of the Section of Surgery of the Academy.

UK Receives $9,000 Grant

The University of Kentucky has received grants totaling $9,000 from the Smith Kline and French Foundation, a charitable trust set up by Smith Kline and French Laboratories. $3,000 goes for support of a new Chairman of the department of medicine, E. D. Pellegrino, M.D., professor and chairman. The remaining $6,000 is for support for a new chairman of the department of psychiatry, Joseph B. Parker, Jr., M.D., professor and chairman.

Pediatricians Hold Election

Murvel C. Blair, M.D., Frankfort, has been elected new president of the Kentucky Pediatric Society to succeed J. J. Glaboff, M.D., Louisville. Other new officers are: Noble T. MacFarlane, M.D., Lexington, vice-president; and Joseph Liebman, M.D., Frankfort, secretary-treasurer.

In Memoriam

MORGAN R. ADAMS, JR., M.D.
Louisville
1929-1961

Morgan R. Adams, Jr., M.D., health officer for Shelby and Spencer Counties, died April 25 at Veterans Administration Hospital.

Doctor Adams, a native of Louisville, was a graduate of Duke University and received his medical degree from the University of Louisville School of Medicine. During the Korean War he served as a Navy lieutenant. He was 31.

EVERETT MORRIS, M.D.
Louisville
1871-1961

Everett Morris, M.D., a pioneer in tuberculosis investigation and treatment died May 17 at Veterans Administration Hospital in Louisville. A 1906 graduate of the University of Louisville School of Medicine, he served in the Army Medical Corps many years.

A native of Henry County, Doctor Morris was a former president of that county's Medical Society and of the American College of Chest Physicians. He was also a former officer of the National Tuberculosis Association. He became a captain in the Army Medical Corps in World War I., serving as head physician at Army General Hospital at New Haven, Conn. More recently he had been with hospitals in California. He came to Louisville after his retirement about 10 years ago.

CHARLES GARFIELD CROWDER, M.D.
Central City
1880 - 1961

Charles Garfield Crowder, M.D., Central City, died May 15 at Muhlenberg Community Hospital.

A 1906 graduate of the University of Louisville School of Medicine, Doctor Crowder had practiced in Central City and Muhlenberg County all his life. He was 81.

Heinz Lord, M.D., Secretary General of the World Medical Association, died February 4 while attending a Rural Health Study Conference in Chicago. Louis H. Bauer, M.D., retired Secretary General has been recalled until a new Secretary General can be appointed.

The United States Public Health Service announces the award of $127,364 in grants for seven new nursing projects dealing with hospital and public health nursing, patient teaching in the ambulatory services, maternal and child health, and the health of student nurses. An award of $19,615 has also been made for four new predoctoral fellowships for training in nursing research. Currently 67 nurse fellows have awards for study at a total of 25 colleges or universities.

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County Society Reports

Fayette County

The annual dinner meeting of the Fayette County Medical Socicty was held May 2. Approximately 225 doctors from 18 counties attended.

"Shirt Sleeves and No Wonder Drugs, the Story of a Kcntucky Triumph," was the topic of Arthur Kecncy, M.D., Louisville, who was the featurcd speaker. Joseph H. Saunders, M.D., Lexington, Fayette County president, presided at the meeting which was arranged by M. R. Gilliam, M.D., Lexington.

McCracken County

"Periodic Health Examinations" in industry was the topic of a talk given before the March 22 meeting of the McCracken County Medical Society. Guest speaker was Carl U. Dernehl, M.D., Assistant Medical Director, Union Carbide Corporation, New York City.

At the business session of the meeting a letter from the AMA Communications Division, Department of Program Development, was reported. It described an editorial writer's kit and a speaker's kit containing information on the Kerr-Mills law and the King bill with the AMA's stand on each. William B. Haley, M.D., Paducah, reported on additional equipment available for civil defense and that the program was now coordinated by both the County Health Officer and Doctor Haley.

New business consisted of the acceptance of two new members: Norman A. Parrott, M.D., and Paul E. Davis, M.D., both of Paducah. A letter from the Warren County Medical Society was read and it was recommended that a similar lcttcr written by the McCracken County Medical Society be sent to the Warrcn County group.

Attendance was urged at the annual County Society Officers Conference in Lexington.

Dr. Halstead Takes New Post

James Halstead, M.D., formerly assistant vice president and director of postgraduate medical education for the University of Kentucky Medical Center, left for a new position in Detroit on May 31.

He will assume his new duties as head of the Department of Medicine of the Metropolitan Hospital and Clinics in Detroit on June 1. Mrs. Halstead, the former Anna Roosevelt, had served as a staff assistant in the office of William R. Willard, M.D., dean of the U of K College of Medicine. Doctor Halstead is a graduate of Harvard Medical School and was chairman of the Department of Medicine, University of Shiraz in Iran before coming to Lexington.

Journal Adds New Department

The Journal of KSMA is adding a new department beginning with this issue. This is a page of questions and answers about Blue Shield. The idea for this department came from the KSMA advisory commission to Blue Shield and has been approved by the editors and the advisory committee to the editors. It will be carried on a monthly basis and readers are invited to submit their questions on this subject.

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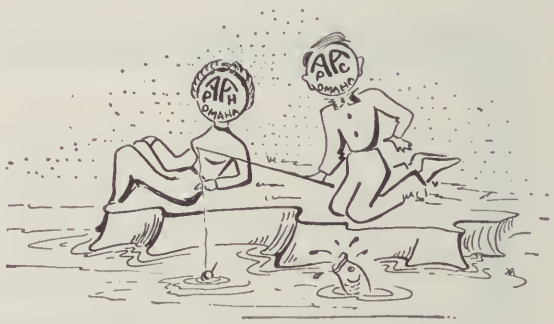
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NEWS ITEMS

Ernest N. Hart, Jr., M.D., a 1957 graduate of the University of Louisville Medical School, has begun medical practice in Calhoun in association with W. G. Edds, M.D. A native of Decatur, Ala., Doctor Hart took his internship and residency at Lackland Air Force Base, San Antonio, Texas. He served in the Air Force with the rank of captain.

Kenneth B. Moore, M.D., has joined the staff of the Veterans Administration Hospital in Lexington where he will limit his practice to psychiatry. A graduate of the University of Kansas School of Medicine in 1947, he interned at University Hospital, Ann Arbor, Michigan, and took residency training in psychiatry at the Neuropsychiatric Institute, University of Michigan, and Ypsilanti State Hospital. He is associated with the department of psychiatry, University of Kentucky Medical Center. He was formerly on the staff of the Ypsilanti State Hospital.

Herbert B. Hargett, M.D., a graduate of the University of Louisville Medical School in 1943, is now associated with M. C. Baker, M.D., and R. Glen Boles, M.D., in Louisville. He will limit his practice to ophthalmology. Doctor Hargett, formerly in private practice in Springfield, Ohio, interned at Springfield City Hospital and took his residency training at New York University and Veterans Hospital in Louisville. He served in the U. S. Army Medical Corps for two years following his internship.

Carl H. Fortune, M.D., Lexington, a graduate of Transylvania College, will receive an honorary degree of Doctor of Science from that school at its Commencement exercises June 11. He received his M.D. degree from the University of Louisville School of Medicine and serves on the Board of Curators of Transylvania College.

Benjamin Franklin Workman, M.D., Brooksville, is retiring after 50 years of medical practice. A 1910 graduate of the University of Louisville Medical Department, Doctor Workman practiced in Powersville from 1916 to 1948 before moving to Brooksville.

Edward Murray, M.D., retired Lexington physician, received a 40-year pin at a Court of Honor of Boy Scout Troop 86. Lucien Rice, Scout district executive, presented the pin.

Robert Straus, M.D., chairman of the University of Kentucky Medical Center's department of behavioral science, is chairman of the Cooperative Commission on the Study of Alcoholism. The commission was created last year to administer a $1,000,000 grant from the National Institute of Mental Health.

V. C. Moseley, M.D., Millersburg, is retiring from active medical practice. A graduate of Kansas City University of Physicians and Surgeons, he has practiced in Millersburg for 27 years. Dr. Moseley and his wife were honored at a community open house on April 5.

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NEWS ITEMS

Alfonso V. Wilwayco, M.D., Franklin, has been appointed health officer for Logan, Simpson, and Allen Counties. Doctor Wilwayco, a native of Manila, Phillipine Islands, is a 1955 graduate of St. Thomas Medical School, Manila. He took his internship and one year of residency training at Jewish Hospital, Cincinnati. He also took three years of residency training at Reading, Pa.

The University of Kentucky Medical Center has received a five-year grant of $141,180 for psychiatric instruction. The United States Public Health Service grant will provide $28,236 a year, with $3,000 for student fellowship, and $25,236 for salaries and equipment.

M. V. Wicker, M.D., Wayland, was honored by more than 200 patients, associates and friends at a dinner honoring his 76th birthday and his 50th year of medical practice.

Arthur R. McCurry, M.D., has begun practice in Middlesboro in association with Charles D. Cawood, M.D., and S. H. Flowers, M.D. He will limit his practice to surgery. A 1955 graduate of the University of Tennessee Medical School, Doctor McCurry took his internship and residency at St. Joseph Hospital, Memphis, Tenn. He served two years in the U. S. Air Force with the rank of captain before coming to Middlesboro. He had practiced previously in Memphis.

Emmet F. Horine, M.D., Brooks, Ky., was state chairman for National Library Week, April 16-22. A retired cardiac specialist and professor emeritus of the University of Louisville Medical School, Doctor Horine is official historian of the KSMA and has also written a number of scientific monographs and books.

Wyatt Norvell, M.D., New Castle, discussed regional Civil War history at a quarterly meeting of the Oldham County Historical Society on May 12. Doctor Norvell is an authority on that topic.

M. A. Yelton, M.D., Burlington, is retiring after practicing medicine in Boone County for 48 years. A native of Bracken County where he practiced for seven years, he is a 1905 graduate of the University of Louisville Medical Department.

The Gill Memorial Eye, Ear and Throat Hospital, Roanoke, Va., held its 34th Annual Spring Congress in Ophthalmology and Otolaryngology and allied specialties in April. Nineteen guest speakers were invited and a total of 52 lectures was heard.

The World Medical Association announces the annual meeting of its United States Committee will be held June 27 in New York. The XVth General Assembly will be held in Rio de Janeiro, Brazil, September 15-20.

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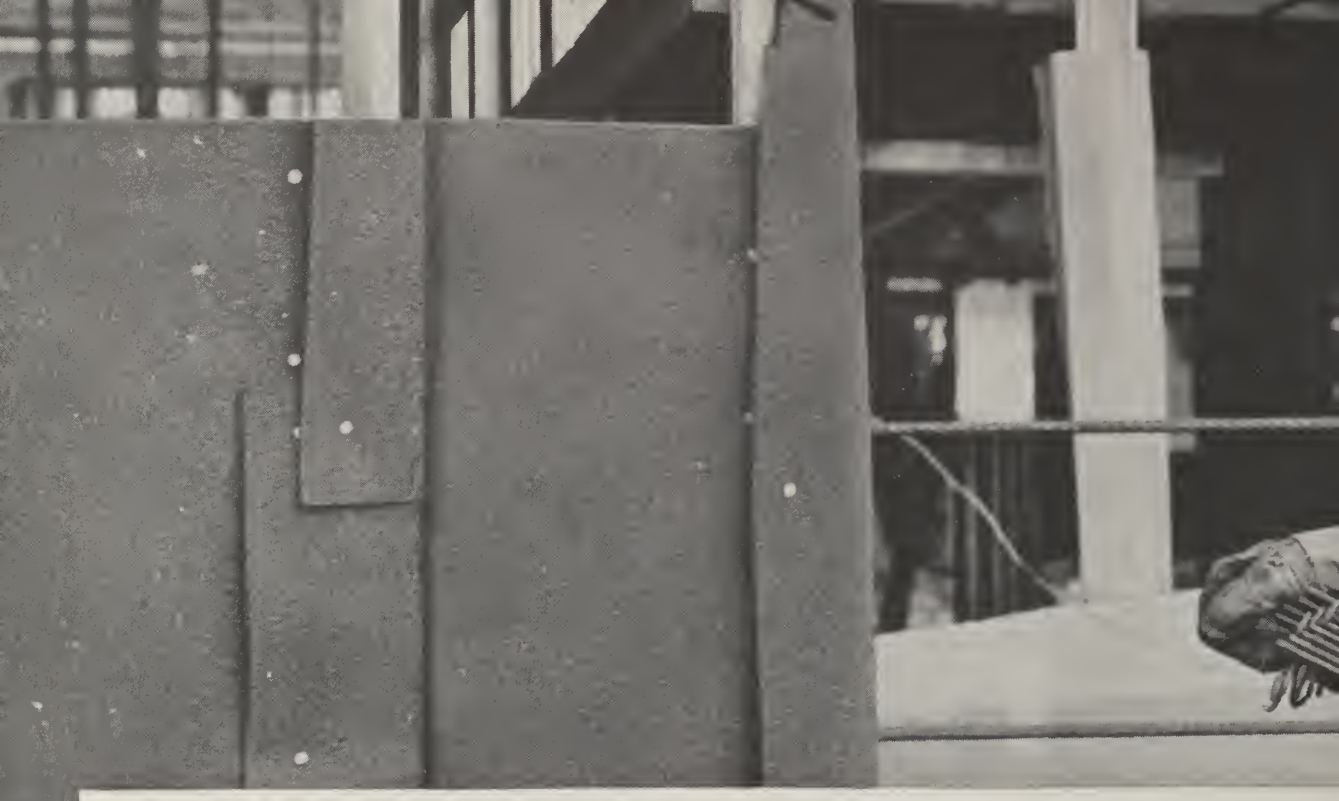
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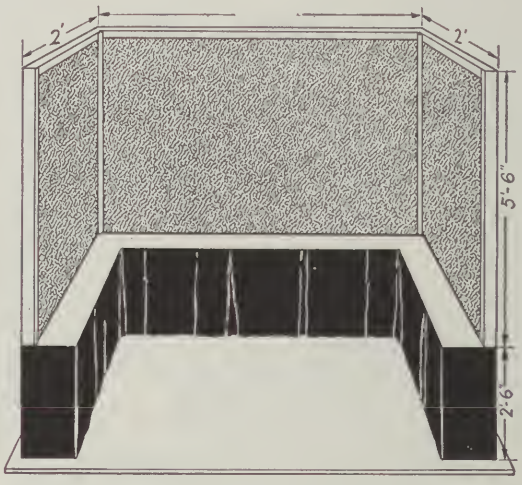
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Cost of transporting exhibits to the meeting must be borne by the individual exhibitor as well as costs of cards, signs, etc., which are a part of the exhibit.

View boxes, furniture, decorations, etc., may be rented, if desired, by applying directly to Jos. T. Griffin Company, 704 West Main Street, Louisville 2, who supply equipment for the annual K.S.M.A. meeting.

Building Committee

George F. Brockman, M.D., Greenville, Chairman

Kentucky Hotel, Louisville **April 20, 1961**

The building committee met for the purpose of opening bids from the six contractors who had been invited by the architect to submit their estimates on the total construction cost. There was less than four per cent difference in the low and high bids.

The contracting firm of Fred J. Lichtefeld & Son was the low bidder. Mr. Stanley Lichtefeld was contacted and appeared before the members of the committee that afternoon for discussion.

(After the necessary technicalities had been taken care of, the contract for the construction of the new building was let on May 10. It was estimated that it would take approximately seven months to complete the structure.)

Committee on Physicians Placement Service

Delmas M. Clardy, M.D., Chairman

Louisville **May 4, 1961**

The KSMA Committee on Physicians Placement Service met at the Kentucky Hotel, Louisville, on Thursday, May 4 to discuss the manner in which the Placement Service is being handled. Delmas M. Clardy, M.D., Hopkinsville, chairman of the committee, and Director of Field Services, explained procedures used when requests were made for doctors and when doctors request help in finding locations. A discussion was held and there were no suggestions for improvement. It was agreed to continue handling such requests in the same manner.

Committee on Third Party Medicine

John S. Harter, Chairman

Louisville **April 20, 1961**

A statement was formulated on salaried employment at the Meeting of the Committee on Third Party Medicine, April 20 in Louisville. This statement has been sent to the law department of the AMA for their comments. Another statement was presented by KSMA's Legal Counsel pointing out the problems involved in setting up professional corporations in order to obtain tax approved pension plans. This statement will be sent out to KSMA members with the Secretary's Letter in the near future.

Insurance Committee

John Dickinson, M.D., Glasgow, Chairman

Brown Hotel, Louisville **March 9, 1961**

At its first meeting this year, the KSMA Insurance Committee heard a report by Blue Cross-Blue Shield representatives on alleged abuses and over-utilization in a Kentucky community. It was decided to turn the matter over to the appropriate judicial body of KSMA for its jurisdiction.

The matter of privileged communications was also discussed. Since this is also being studied by the Hospital Committee, it was decided that a statement on this matter be sent to that committee in order to avoid divergent opinions.

A complaint was studied concerning a cancellation of a policy by the insuring company upon the applicant's initial claim. From the information presented, the committee was of the opinion that the insuring company was in error and asked that further information be secured.

The committee also discussed possible legislation to cover certain standard provisions in policies for health and accident benefits.

Technical Advisory Committee to Governor's Advisory Council on Indigent Medical Care

Clyde C. Sparks, M.D. Ashland, Chairman

Frankfort **May 3, 1961**

The Technical Advisory Committee to the Governor's Advisory Council on Indigent Medical Care met Wednesday, May 3, in Frankfort. Committee members discussed the first three months' use of the program, better use of an educational program, and possible expansion of the program. After consideration, the members of the committee agreed to make the same recommendations they had previously made.

KSMA Program Committee

Frank M. Gaines, M.D., Chairman, Louisville

Brown Hotel, Louisville **April 26, 1961**

Careful attention was given to planning the overall scientific program for the 1961 Annual Meeting to be held in Louisville Tuesday, Wednesday and Thursday, September 19, 20 and 21.

Seven of the specialty group sessions will be held Tuesday afternoon and another seven on Thursday morning. A final draft of the scientific program was agreed upon after full consideration.

The program will feature a panel for each of the three days and will present a total of fifteen prominent speakers.

Clinical Society Hears Dr. Terry

Luther L. Terry, M.D., surgeon general of the United States Public Health Service, says the United States will need 20 more medical schools by 1970 if it is to overcome the shortage of medical school graduates.

Doctor Terry was guest speaker at the 15th annual meeting of the USPHS Clinical Society held in April at the Public Health Service Hospital, Lexington.
Pertinent Paragraphs

Proctologists Pick Dr. Cooper

Wilford L. Cooper, M.D., Lexington, was chosen president-elect by the Ohio Valley Proctologic Society at its meeting in Cincinnati on May 12. Marvin A. Lucas, M.D., Louisville, is a member of the executive council of the Society. Principal speaker at the meeting was Raymond Jackman, M.D., chief of proctology at the Mayo Clinic, Rochester.

Answers to Questions About Your BLUE SHIELD

Q. Is the Preferred Blue Shield Plan available to all applicants?

A. Yes, however, the dues for the Preferred Plan are higher than for the Standard Plan, and applications must be underwritten.

Q. Why not eliminate the Standard Plan and change all present subscribers to the Preferred Plan?

A. Many have changed. Blue Shield was inaugurated by the KSMA in 1949 for the people of Kentucky, to help them voluntarily prepay a part of their medical needs. In Kentucky, where the per capita income is approximately $1400 per year per person, the Blue Shield Board recognized the need of keeping available plans that will allow all income groups the privilege of purchasing a prepayment plan. The Standard Blue Shield Plan is needed in the low income groups. Blue Shield is constantly urging members to increase protection. The decision, though, is voluntary.

Q. How can we properly identify the type coverage carried by our patients who have Blue Shield?

A. Each Blue Shield subscriber has been issued an Identification Card which gives his particular coverage code. Each physician's office has been given a complete list of Blue Shield coverage codes to be used in matching the subscriber's code numbers to the appropriate code for identification.

Q. Does Blue Shield have any plans to offer new benefits and more coverage to enable a member to prepay a greater portion of total medical costs?

A. Yes. The KSMA Advisory Commission to Blue Shield assisted by the Blue Shield Staff is now studying new and expanded coverages. These include an improved medical endorsement to help pay for in-hospital non-surgical cases, an extended benefit plan and a supplemental catastrophic coverage. Much research and actuarial work has been done and the entire scope of new benefits should be available within the next three months. Parts of the new program are available now.

Q. I had a patient ask me if my fee for service would be increased if he carried Blue Shield. I answered an emphatic *no*. Are there doctors that follow this practice?

A. If generally done, it would destroy prepayment. The vast majority of doctors would not increase their fee just because a patient has Blue Shield, but unfortunately, the public doesn't realize this. The doctors could help eliminate this belief by discussing charges with the patient and explaining them.

Q. If we have a suggestion to improve or change our Blue Shield Plan, to whom do we write?

A. Write the President of the Blue Shield Board of Directors, 3101 Bardstown Road, Louisville 5, Kentucky. The Blue Shield Board encourages this practice.

Q. Many doctors have expressed their opinions that there are inequities in the Blue Shield Schedule of Indemnities. Is action planned to correct these inequities?

A. Yes. The KSMA Advisory Commission to Blue Shield has been working for several months to re-evaluate the present schedule of the Standard Blue Shield Plan. The revised schedule will be completed in the near future.

Pertinent Paragraphs

The Second Middle Eastern Mediterranean Paediatric Congress will be held in Hacettepe, Ankara Turkey, September 6-9. All pediatric physicians and surgeons and those engaged in investigative work in any of the fields allied to pediatrics who reside in the Middle East and Mediterranean areas are invited to participate. Those qualified who reside outside these areas are welcome as observers. The official languages of the Congress will be English, French and Turkish.

The 24th annual exhibition of the American Physicians Art Association will be held June 26-30 in New York in conjunction with the Annual Meeting of the AMA. The exhibit will include works of sculpture, painting, crafts and photography by physicians throughout the United States. Further information can be obtained from Alfred A. Richman, M.D., Secretary, 307 Second Ave., New York 3, N. Y.

The AMA's Council on National Security is sponsoring the ninth annual Conference on Disaster Medical Care set for June 24 in New York. "Defense Training for All—A Resource for National Defense" has been set as the theme and will be developed by the United States Air Force Medical Service. For further information and advance registration, write to the AMA Council on National Security, 535 North Dearborn Street, Chicago 10, Ill.

The New York State Journal of Medicine announces the appointment of William Hammond, M.D., as editor. Assistant editor for the past three years, he succeeds the late Laurance D. Redway, M.D.

"The Physician and the Total Care of the Cancer Patient" is the topic of the 1961 Scientific Session, to be held in conjunction with the American Cancer Society's annual meeting, October 23-24, in New York. For further information, write: Professional Education Section, American Cancer Society, 521 West 57 Street, New York 19, N. Y.

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IN THE BOOKS

OBSTETRICS: J. P. Greenhill, M.D., F.A.C.S., F.I.C.S. (Hon.), published by W. B. Saunders Co., Philadelphia and London; 1098 pages; price $17.

The twelfth edition of this classic work on Obstetrics does not differ a great deal from the eleventh edition which was published in 1955. The format is about the same. There have been some changes in the chapter titles; however, most of these changes have been minor ones. There are approximately the same number of pages with slightly more illustrations in the latest edition.

Dr. Greenhill again has enlisted the aid of a great many contributors to this edition, as he did in the last edition, and we note that there are 23 contributors listed in the front of the book, having written various parts or chapters of this new work. I am sure that by this means we have a text of very high quality, and one that I think the late Dr. Joseph B. DeLee would be proud of as the successor to his original work. However, such a text that is composed largely of various contributors suffers from readability, and when one reads this text and compares it with the easy readability and interesting style of Dr. DeLee, one is impressed that however more complete this book may be it does not lend itself to the easy and interesting readability that the earlier editions had.

This text is written primarily for the medical student and, as such, fulfills its function well. It is also an excellent reference work with complete and up-to-date bibliography at the end of each chapter, so that this book can be recommended to student, general practioner, and specialist alike. It remains one of the two or three outstanding works in the English language on Obstetrics.

Robert C. Long, M.D.

LIGHT COAGULATION: by Gerd Meyer-Schwickerath, M.D., translated by Stephen Drance, M.B., F.R.C.S., published by The C V. Mosby Co, St. Louis, 111 pages; price, $9.50.

This volume brings together the author's experiences in the use of a physical modality, light, for the treatment of various intra- and extraocular diseases.

Among the various disease states covered are: retinal detachment, intraocular tumors, vascular proliferations, and external eye lesions. A general description of the instrument and its application is given and illustrated by diagrams.

Certain limitations in retinal detachment work are outlined and its advantages for sealing small retinal holes or use in prophylactic retinal treatment to prevent detachment is given. A chapter on iris coagulation to fashion a new pupil is present, and is one of the various ingenious uses to which this technique can be put.

Prof. Dr. Meyer-Schwickerath has made an extremely valuable contribution to the field of ophthalmology with his introduction of light coagulation. Many larger centers are now practicing this method and valuable data is being obtained. This volume supplies the necessary information for a basic understanding of the process.

Roderick Macdonald, Jr., M.D.

PRACTICAL CLINICAL MANAGEMENT OF ELECTROLYTE DISORDERS: by William J. Grace, M.D.; published by Appleton-Century-Crofts, Inc., New York City; 144 pages; price, $4.95.

This small compendium is intended to provide the clinician with bedside reference for the usual problems in electrolyte imbalance. It is not suitable nor intended to be a reference text.

Consequently, an adequate bibliography is provided at the end of each chapter for further reading. To provide further adaptation to essential clinical problems requiring immediate treatment, the authors have presented a case report for each facet of electrolyte imbalance to illustrate their method of diagnosis and treatment.

The general context of the small book is made up in this way, such as, "What happens in vomiting or prolonged gastric suction or akalosis. What happens in heart failure, water, salt retention with low serum sodium, renal disease with acidosis and uremia, or acute renal failure, uncontrolled diabetes, acidosis and dehydration," and so on.

The more recent developments in the field of electrolyte disturbances as related to adrenal steroids, such as the low potassium syndrome, aldosteronism, magnesium deficiency and so on, are well covered.

The author brings out several very practical and yet very helpful gems of thought in regard to treatment approach to electrolyte disorders, such as the use of 2% ammonium chloride solution in severe akalosis with marked hypochloremia. Likewise, he describes the "Luckey" regime, in resistant intractable congestive failure due to electrolyte imbalance. He also points out that the use of stored blood which contains an exceedingly high concentration of potassium can be extraordinarily detrimental if infused into a patient with renal failure who also has potassium retention.

These things are known, of course, but the author points them up by crystallizing these helpful gems of information without delving into more involved detailed discussion. Specific treatment of the sodium and potassium-losing type nephritity, the employment

(Continued on Page 623)

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From the files of the COMMITTEE FOR THE STUDY OF MATERNAL MORTALITY



CASE #87—A 37 year old colored gravida 4 para 3, consulted her physician on July 18, 1959, in the second trimester of pregnancy. The expected date of delivery was December 7 according to the menstrual history. Serologic tests for syphilis were negative; the patient was Rh positive.

	Month of Pregnancy						
Month	4	5	6	7	8	9 1	2
Date	7/18	8/15	9/17	10/17	11/14	11/28	12/5
Blood Pressure	100/60	102/60	100/60	110/70	104/70	102/78	102/70
Weight	125¾	131½	136½	140¼	148	149¼	149¾
Urine	Neg	Neg	Neg	Neg	Neg	Neg	Neg

The past history was non-contributory. In July, 1956, the same physician had delivered her uneventfully of a girl weighing 8 pounds, 10 ounces under saddle block anesthesia with a midline episiotomy and low forceps.

After spontaneous onset of labor, the patient was admitted to the hospital at 4:00 a.m. on December 17, 1959. She was taken directly to the delivery room, where examination showed the cervix to be completely dilated; the fetus lay in cephalic presentation at a plus two station. The membranes had ruptured spontaneously on the way to the delivery room. Nitrous oxide and oxygen were administered, and the attending physician was called. He arrived at approximately 4:15 a.m. and was told by the intern that the head was on the perineum. The physician told the intern to deliver the patient immediately rather than waiting until he, the attending physician, had changed clothes and scrubbed. The patient was delivered spontaneously of a 9 pound male infant in good condition. The placenta followed spontaneously. Although no retroplacental clot was noted and the placenta was intact, the patient began to bleed moderately. Examination showed a second degree laceration of the perineum; the fundus was firm. A dilute pitocin infusion was started, and blood was sent for typing and crossmatching at 4:30 a.m. The entire vagina displayed a generalized, non-extending, edematous hematoma of the lower vagina and perineum. The blood pressure at 4:45 a.m. was 60/0. A levophed infusion was started intravenously.

A ring forceps placed on the cervix to expose it for examination produced a laceration of the friable, ecchymotic tissues. A consultant was called when difficulty in getting adequate exposure was encountered. The vagina was packed, and the fundus was anteflexed in an attempt to control the bleeding. As fluids infiltrated in both arms, a cut-down was done on both ankles. The blood which oozed through the vaginal packing did not clot, nor was there any clotted blood in the kick pan. At 6:00 a.m., 2 grams of fibrinogen were given under pressure, and the first 500 cubic centimeters of whole blood, which had been obtained from the Red Cross, was started at 6:10 a.m., together with 100 mg of solu-cortef. A second 500 cubic centimeter transfusion of whole blood was started at 6:45 a.m. No peripheral pulse could be felt and no blood pressure reading could be obtained, even though strong aortic pulsations were palpable.

The patient was returned to lithotomy position to determine the extent of the cervical laceration. Both cut-downs were functioning satisfactorily, although it was still impossible to puncture a vein in either arm without producing bleeding from the venipuncture site. The avulsed portion of the cervix was excised, and the defect was repaired. No other defect was demonstrated. Since bleeding persisted in spite of sustained fundal contraction, the fundus and vagina were again packed and a Foley catheter was inserted into the bladder. A small amount of urine was obtained; it was grossly normal in appearance, but no urinalysis was made. Two more grams of fibrinogen were given under pressure at 7:00 a.m. together with 1/150 grain of atropine subcutaneously to dry the tracheobronchial tree. Since the patient continued to bleed steadily through the vaginal packing without any evidence of clot formation, a third injection of 2 cubic centimeters of fibrinogen was given at 7:30 a.m. At this time, no apical heart beat could be ausculted; breathing was shallow. Oxygen was being administered by mask, and another whole blood transfusion was started at 7:35 a.m. Calcium gluconate was given intravenously and adrenalin diluted in saline was injected into the heart to no avail.

The patient was pronounced dead at 8:42 a.m., 4½ hours postpartum. She had been given 2000 cc of whole blood, 6 grams of fibrinogen, and 200 mg of solu-cortef. The attending physician wrote a final clinical diagnostic impression of irreversible afibrinogenemia with possible amniotic fluid embolism.

At autopsy, there were no abnormal intra-abdominal findings. Gross and microscopic examination of the lungs failed to support the clinical diagnosis of afibrinogenemia secondary to amniotic fluid embolus.

Comments

The Committee considered this case to represent a direct obstetrical death caused by afibrinogenemia, associated with massive terminal abruptio. The autopsy findings failed to substantiate the diagnosis of amniotic fluid embolism. The tumultuous labor exhibited by the patient may have been responsible for the premature separation of the placenta. Even though this patient died in a large metropolitan hospital, one and a half hours elapsed from the time the blood was ordered until it was available to be administered. Sudden massive hemorrhage of the type sustained by this patient requires immediate replacement transfusion. One method of insuring immediate availability of blood for emergency transfusion is the routine typing of all hospital personnel; such a measure may be one of the positive steps that can be taken in advance for the prevention of such fatalities from hemorrhage as that reported.

Pulmonary Embolism—Mayo

(Continued from Page 570)

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The Arthritis and Rheumatism Foundation offers post-doctoral fellowships, predoctoral fellowships and senior investigator awards in the fundamental sciences related to arthritis for work beginning July 1, 1962. These awards are intended as fellowships to advance the training of young men and women of promise for an investigative or teaching career. Deadline for application is October 31, 1961. For further information and application forms, address the Medical Director, Arthritis and Rheumatism Foundation, 10 Columbus Circle, New York 19, N. Y.

—Sympathy—

Harmony of aim, not identity of conclusion, is the secret of the sympathetic life.

—Emerson

In the Books

(Continued from Page 622)

of peritoneal dialysis in acute renal failure as well as the artifical kidney, consideration of renal tubular acidosis are all mentioned and illustrated by specific case reports.

Another interesting comment by the author which I have not seen in other texts is his recommendation for the abandonment of the term "pre-renal azotemia," and it has been a thought that this merely represents a description of nitrogen retention other than specific renal failure and an inadequacy prior to this of being able to explain retention of nitrogen on a different basis. The author readily points out that this term should be abandoned because we should attempt to understand these mechanisms without applying a non-descriptive and unphysiologically supported term.

The clarity with which the author describes electrolyte abnormality and, as a matter of fact, the degree to which he simplifies the relationship of plasma and tissue electrolyte to digitalis effect and the consequent cardiac manifestations make this book exceedingly useful. He again provides readily available treatment methods in relationship to hypo-potassemia in the presence of digitalis effect, as well as the relationship of sodium and calcium levels to digitalis effect and the ability to improve digitalis intoxication by attempts to lower serum calcium.

In spite of the fact that this fine handbook, "Practical Clinical Management of Electrolyte Disorders," which is a very descriptive title, is certainly not a reference text, it is just the sort of handbook that has been needed for quick reference by house officers, clinicians and medical students in handling patients with electrolyte problems.

I personally feel it would be a welcome addition to anyone's library, but again I would emphasize the fact that, although phases of even the most current concepts of electrolyte imbalance are covered, it is purely on a practical level. However the book is extremely well written and well worth one's perusal.

H. C. Morris, M.D.

"Preventive Medicine in World War II, Volume V," scheduled for publication about June 15, is the latest of 16 volumes to be published in the series "Medical Department, U. S. Army, in World War II." 48 volumes are planned for the series. They may be purchased as a set or individually from the Superintendent of Documents, Government Printing Office, Washington 25, D. C. Other volumes now available are: "General Surgery," "Neurosurgery" (head injuries), "Neurosurgery," volume II (spinal cord and peripheral nerve injuries), "Hand Surgery," "Ophthalmology and Otolaryngology," "Orthopedic Surgery, Mediterranean Theater of Operations," "Physiologic Effects of Wounds," "Vascular Surgery," "Cold Injury, Ground Type," "Dental Service," "Environmental Hygiene," "Personal Health Measures and Immunization," "Communicable Diseases," volume IV, "Hospitalization and Evacuation, Zone of Interior."

PUBLIC HEALTH PAGE

The Hospital and Medical Facilities Survey and Construction Program in Kentucky*

RUSSELL E. TEAGUE, M.D., M.P.H.
Commissioner of Health
Commonwealth of Kentucky

THE Hospital and Medical Facilities Survey and Construction Program has been in effect in Kentucky since the passage of the original Act in 1946. This is commonly referred to as the Hill-Burton Program. Under the program Federal funds are allocated to the various states through the U.S. Public Health Service to be used to match the sponsor's or applicant's funds for construction of the following types of facilities; namely, general, mental, tuberculosis, and chronic disease hospitals, as well as public health centers, diagnostic and treatment centers, nursing homes, and rehabilitation centers.

The following is the status of the program from its beginning up to the present time:

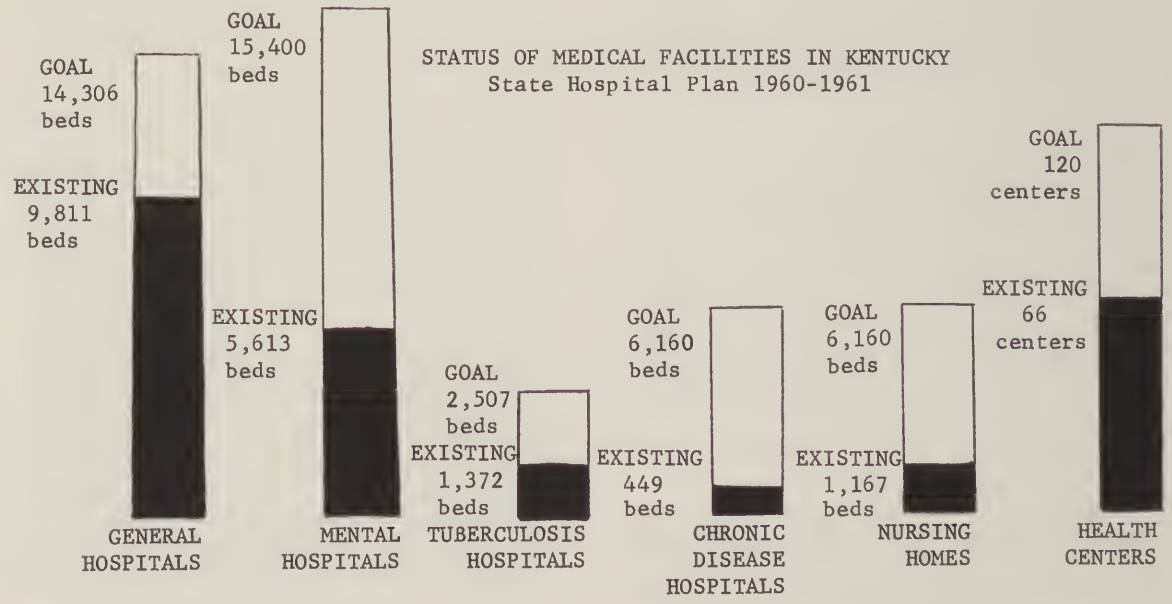
Either Completed or Under Construction
(Including both new facilities and additions to existing ones)

General Hospitals	Mental Hospitals	Tuberculosis Hospitals	Chronic Disease Hospitals	Public Health Centers	Diagnostic & Treatment Centers	Nursing Homes	Rehab. Centers
59	6	7	3	73	2	3	1

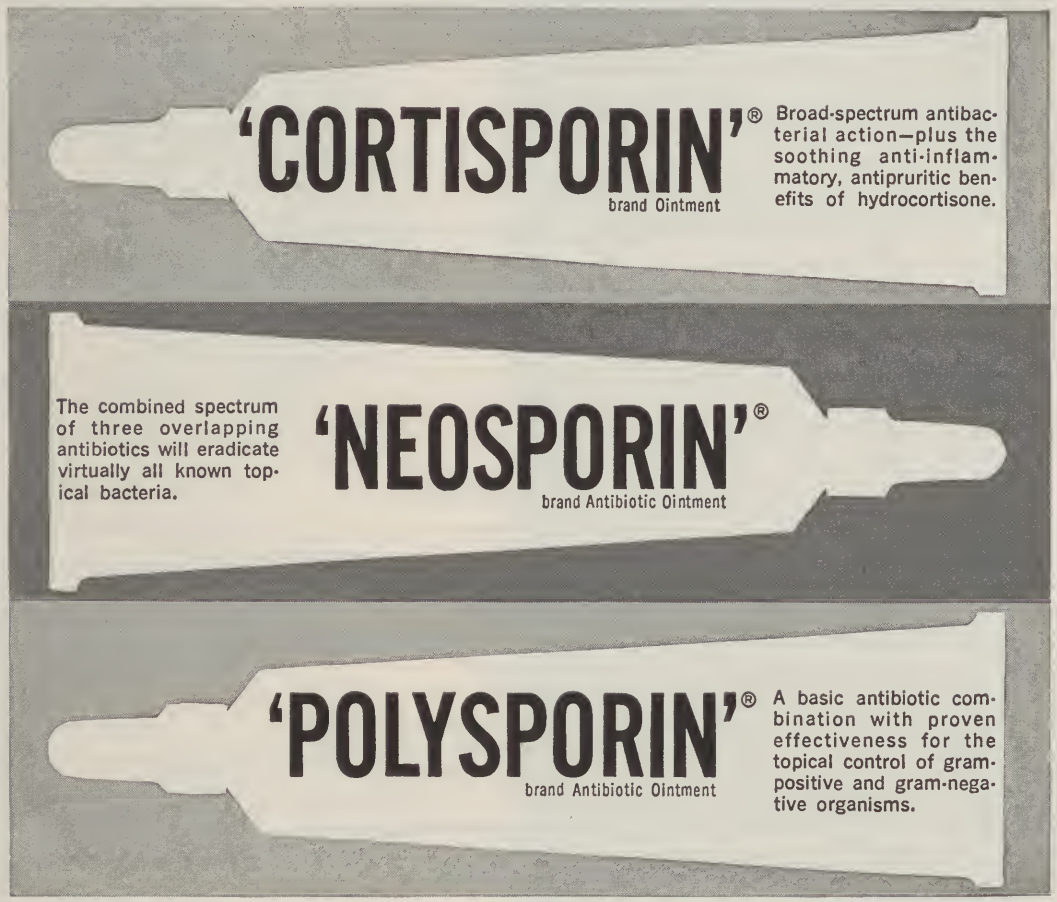
In addition to the above-listed projects, there are other special type projects such as the State Health Department Laboratory, Louisville; the Louisville Medical Center Steam Plant; and seven Schools of Nursing. The total costs of the above referred-to projects are estimated at approximately $150,000,000 which includes Federal and applicants' funds.

At the present time there are requests for approximately twenty additional new projects which cannot be assisted due to the non-availability of Federal funds. However, it is hoped that sufficient money will be appropriated by Congress within the next ten years to meet the most acute unmet bed-needs. Due to the obsolescence of facilities from time to time and due to the increase of population as well as the increase of hospital bed demand, the State at this time still has a long way to go. The chart shown below will give a fair idea as to the goals which it is hoped can be attained for the State.

**This article was prepared by Paul A. Hackney, Director, Division of Hospital and Medical Facilities, State Department of Health, Frankfort, Kentucky.*



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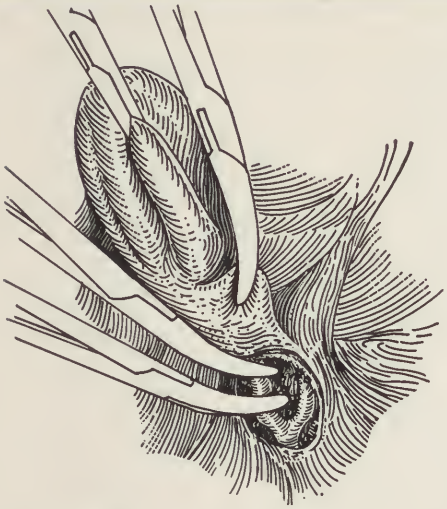
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Source: Farris, J. M., and Smith, G. K.: M. Clin. North America *43*:1133 (July) 1959.

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1. The Composition of Milks, Publication 254, National Academy of Sciences and National Research Council, Revised 1953.
2. Brown, G.W.; Tuholski, J.M.; Saucr, L.W.; Minsk, L.D., and Rosenstern, I.: J. Pediat. *56*:391 (Mar.) 1960.

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The JOURNAL of the Kentucky State Medical Association

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KENTUCKY STATE MEDICAL ASSOCIATION
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inside as well as outside the hospital...
staphylococci usually remain sensitive to

CHLOROMYCETIN

(chloramphenicol, Parke-Davi

That the sensitivity patterns of "street" staphylococci differ widely from those o "hospital" staphylococci is a well-established clinical fact.[1-5] Although strains o staphylococci encountered in general practice have remained relatively sensitive t a number of antibiotics,[6] the problem of antibiotic-resistant staphylococci appear to be a threat to all patients in hospitals today. It is encouraging to note, howeve "...that a relatively small percentage of strains develop resistance to chloram phenicol, despite the consumption of large amounts of this antibiotic."[7]

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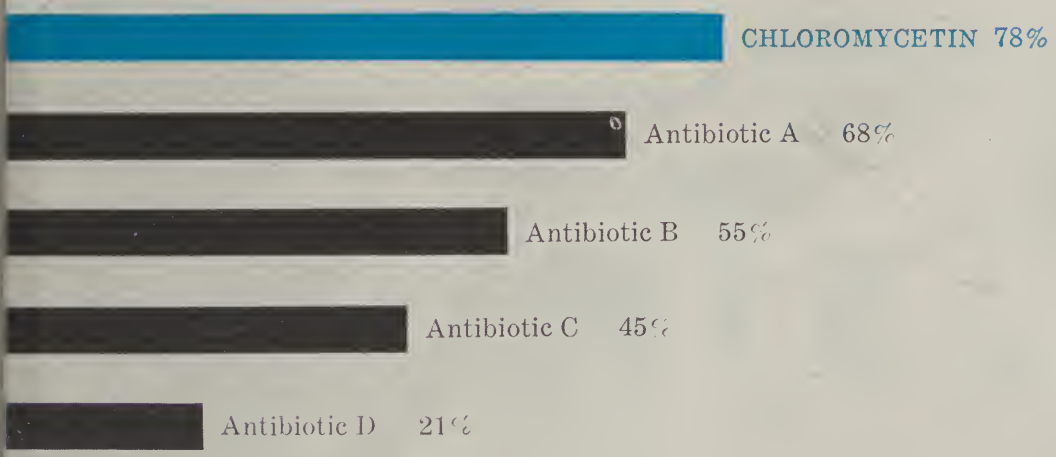
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Precautions: It is essential that adequate blood studies be made during treatment with the drug. Whi blood studies may detect early peripheral blood changes such as leukopenia or granulocytopenia, befor they become irreversible, such studies cannot be relied upon to detect bone marrow depression prior t development of aplastic anemia.



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'hese strains of coagulase-positive staphylococci were isolated from hospitalized patients at a arge county hospital during the year 1959. Sensitivity tests were done by the disc method.

dapted from Bauer, Perry, & Kirby[1]

eferences: (1) Bauer, A. W.; Perry, D. M., & Kirby, W. M. M.: *J.A.M.A.* 173:475, 1960. (2) Fisher, M. W.: *rch. Int. Med.* 105:413, 1960. (3) Cohen, S.: *Circulation* 20:96, 1959. (4) Edwards, T. S.: *Am. J. Ophth.* 8, Part II:19, 1959. (5) Smith, I. M.: Staphylococcal Infections, Chicago, The Year Book Publishers, Inc., 958, p. 148. (6) Petersdorf, R. G.; Rose, M. C.; Minchew, H. B.; Keene, W. R., & Bennett, I. L., Jr.: *rch. Int. Med.* 105:398, 1960. (7) Editorial: *J.A.M.A.* 173:544, 1960. (8) Finland, M.; Jones, W. F., Jr., & Bennett, I. L., Jr.: *Arch. Int. Med.* 104:365, 1959.

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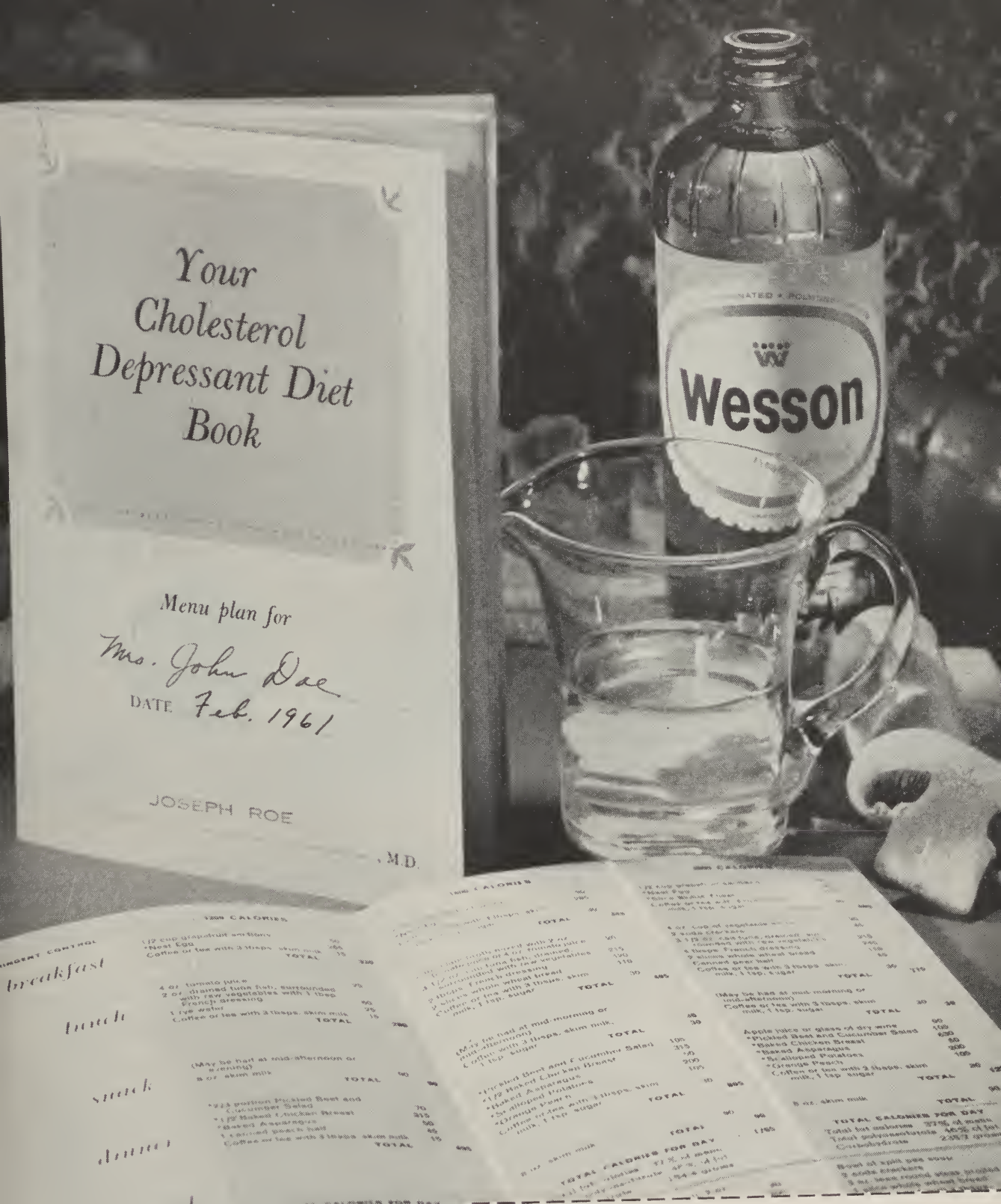
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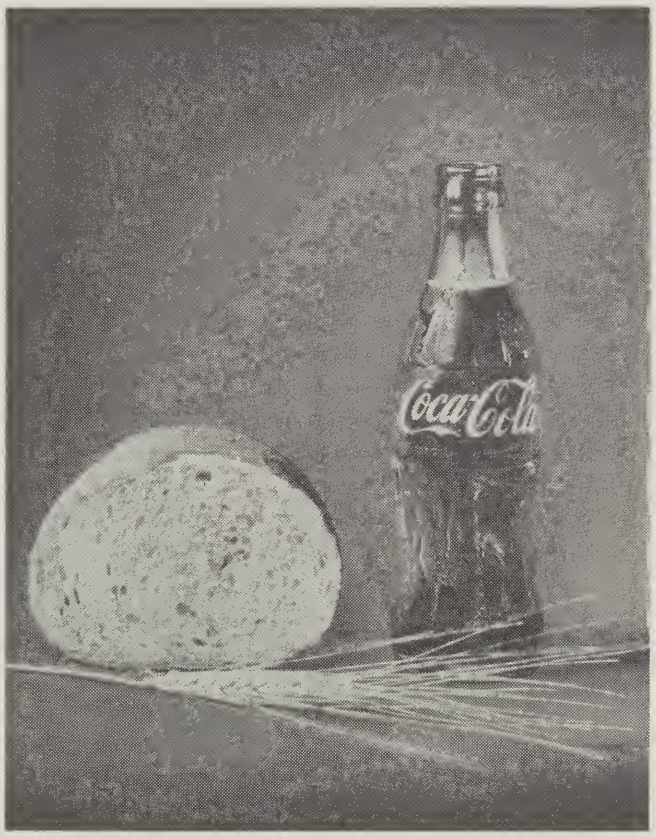
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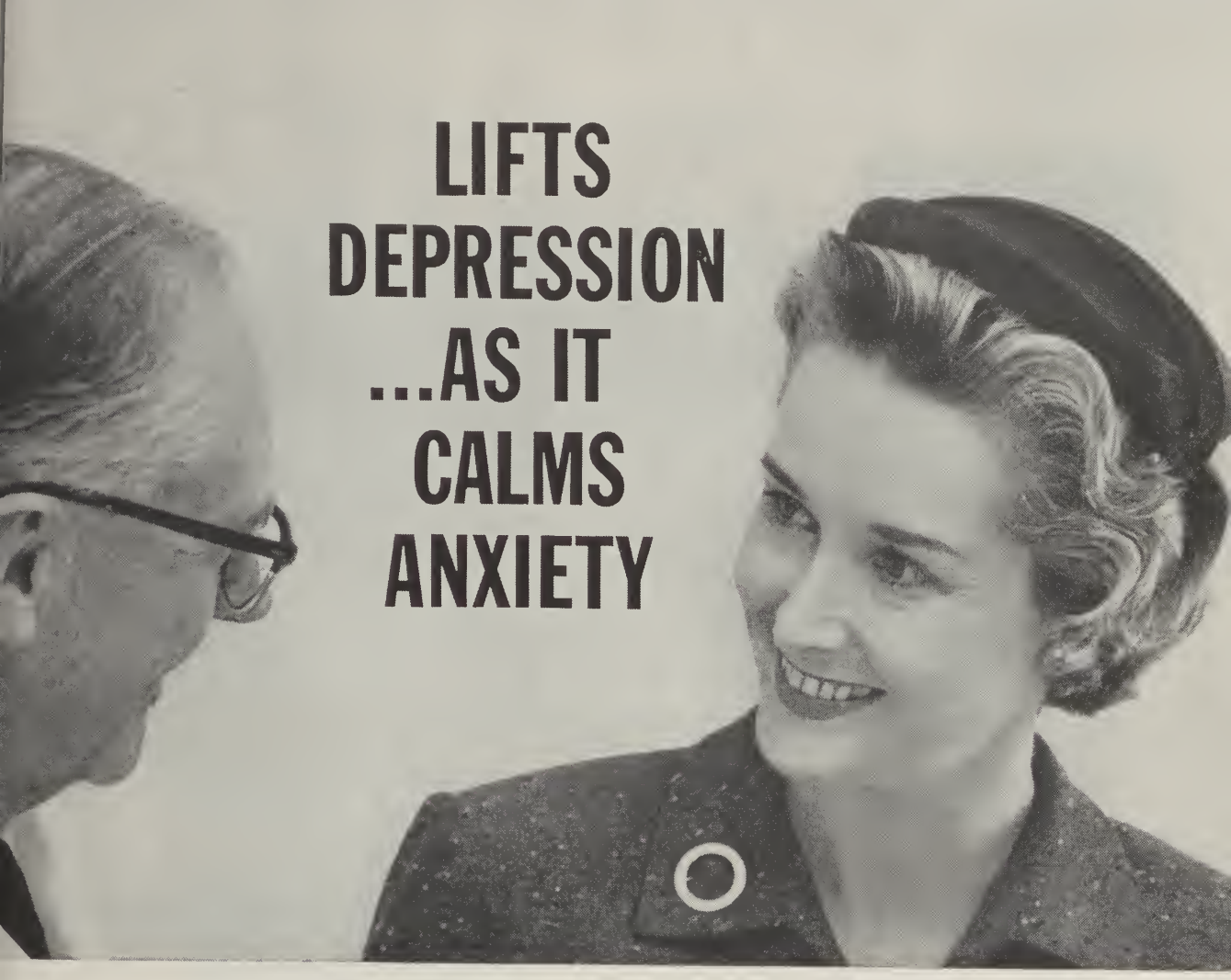
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MESSAGE FROM THE PRESIDENT

THE 21-member KSMA Advisory Commission to Blue Shield, following study at two recent meetings, has recommended to the KSMA Board of Trustees for consideration the so-called Indiana or "pay-all" plan. This is a preferred risk certificate, approved by the individual county medical societies, offered to hourly rated employees of the county.

Under the plan, the members of the county society agree to accept as full payment the fee listed on the schedule agreed upon by this society, unless he has informed the subscriber prior to the rendering of the service that there will be an additional charge. A physician is therefore not obligated to accept the fee listed on the schedule.

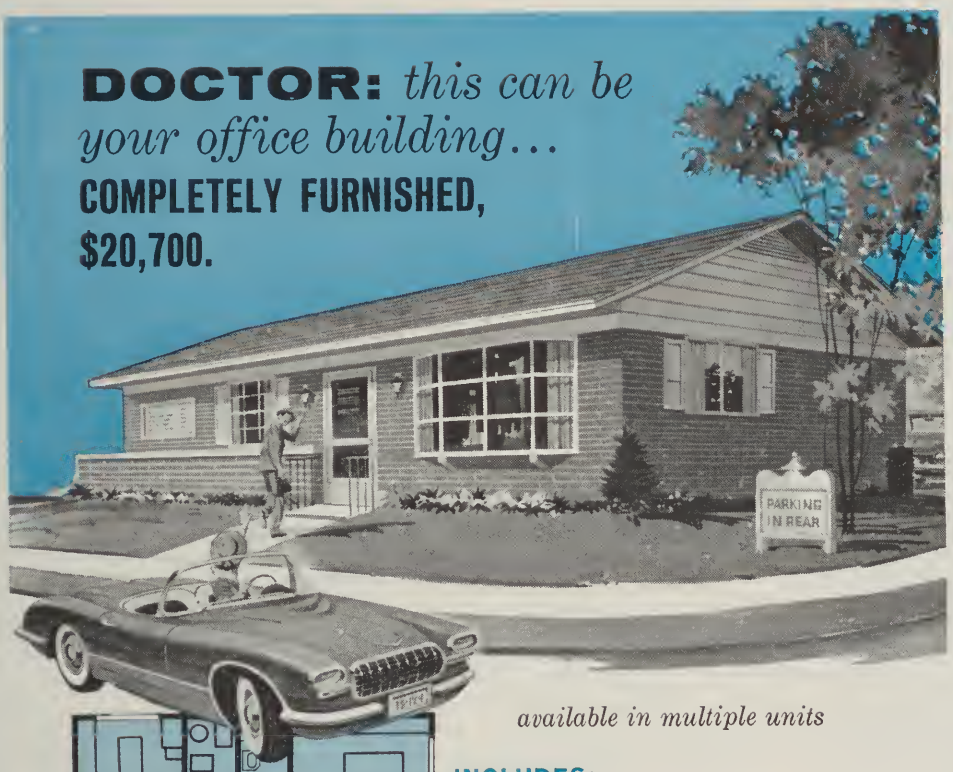
Should a participating physician, after getting into the case, find the fee allowed in the schedule for a given procedure is inadequate to cover his services, he may then appeal to a committee appointed by the county medical society to review the case. If the committee agrees with the physician, the Indiana Blue Shield pays the additional fee.

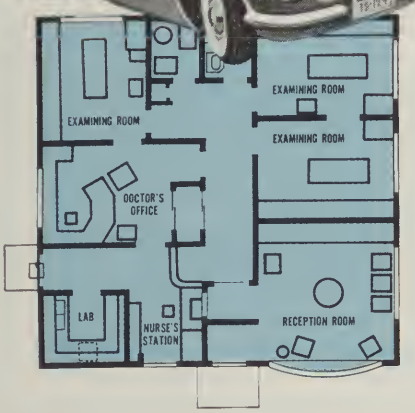
In Indiana, which has long been known as an "indemnity state," experience has been that the so-called "pay-all" plan has a broad appeal in industrial communities. Indiana physicians using the plan feel that the plan makes it possible for Blue Shield to render a broader service to both the hourly rated employees and the doctors. Members of the KSMA Advisory Commission felt it might be of assistance in some Kentucky counties of this type.

Since its inception, the Kentucky Physicians' Mutual, the Blue Shield plan for Kentucky, by decision of the House of Delegates has issued all of its certificates on the indemnity principle. On several occasions attempts have been made to have them issue policies which embodied the method of fee-for-service payment. These endeavors have all failed. When the Indiana plan is presented to the membership of KSMA, it will be pointed out that some feel this is not a fee-for-service plan. While the physician may tell his patient prior to rendering the service that he will charge more, and in case he finds later he has to charge more, even if the local committee sustains him, pressure is on the doctor to accept the fee offered by the Blue Shield. When this plan is presented to you, I hope that each of you will carefully consider whether or not this is a service plan in another disguise and whether the contracting agent is not a third party insinuating himself into the doctor-patient relationship.

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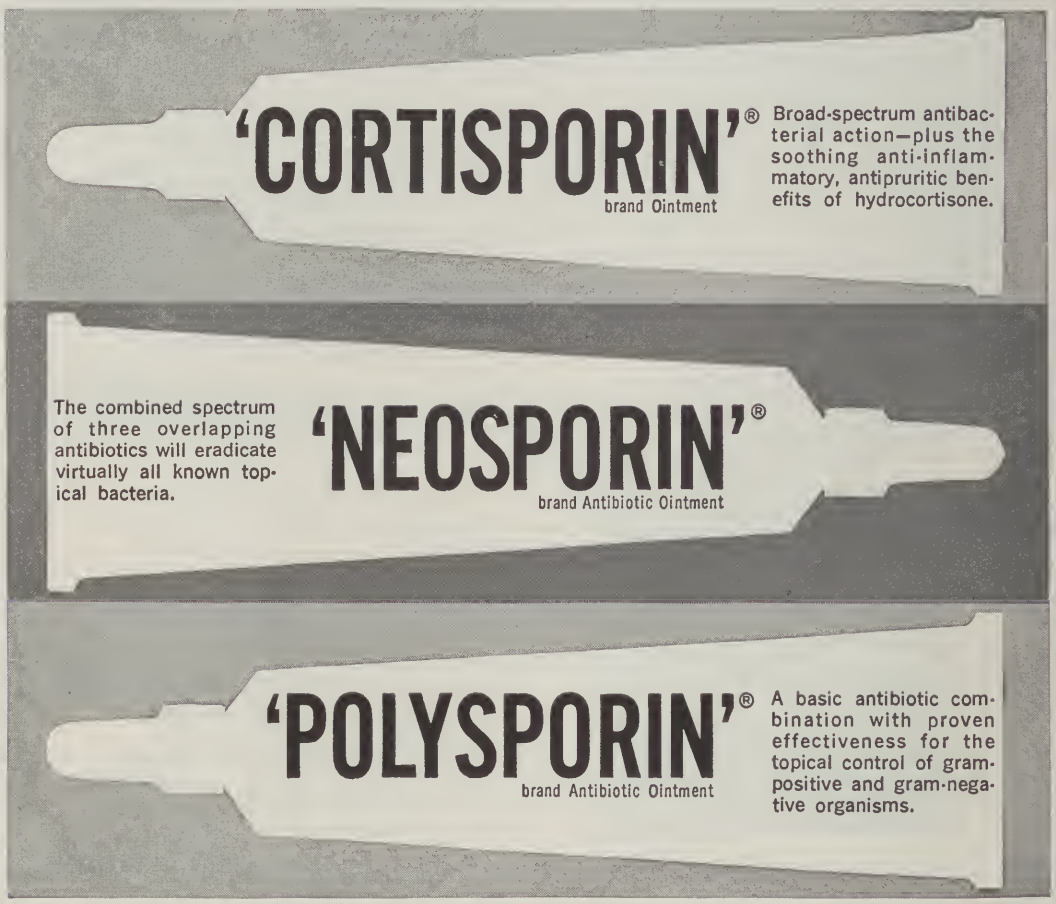
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1. Meyers, G. B.: Ind. Med. & Surg. 26:3, 1957. 2. Murray, R. J.: N. Y. St. J. Med. 53:1867, 1953.

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References: 1. Garber, R. C.: J. Florida M. A. *45*:549 (Nov.) 1958. 2. Lipton, M. I.: Pennsylvania M. J. *64*:60 (Jan.) 1961. 3. Ayd, F. J., Jr.: Psychotropic Drugs, S. Garattini and V. Ghetti, eds., New York, Elsevier Publishing Co., 1957, p. 548. 4. McGettigan, D. L.: West. Med. *1*:8 (Jan.) 1960.

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Standardization of procedure for release of information from a hospital chart is desirable. A signed permission having been obtained, the following information should be sufficient:

1. Patient's name, age, address.
2. Date of admission.
3. Admitting diagnosis.
4. Treatment, including name, extent and date of any surgical operation.
5. Diagnosis as stated at conclusion of pathology report.
6. Final diagnosis.
7. Date of discharge.

The above list should be all the information needed by an insurance or government agency in processing claims and is all the information they are entitled to. A court order should be required for anything more.

Preferential treatment of any plan such as Blue Cross is to be deplored and discouraged. Such a plan, no matter how closely related to hospital management organizations, is not entitled to special favors not granted to commercial insurance companies.

The use of past hospital records in lieu of recent physical examination for applicants for health insurance and life insurance is wrong. Any applicant for health insurance or life insurance should be entitled to a physical examination at a time he or she is in good health. Record taken during hospitalization for an acute illness would show abnormal findings of a temporary nature and so would be unfair to the applicant. Information on the chart could be (and has been) misconstrued and distorted by the insurance company. Instances are known in which insurance companies took symptoms stated in the history and unfairly concluded a wrong diagnosis from symptoms only.

John Dickinson, M.D.

**This article was prepared by John Dickinson, M.D., Chairman of the KSMA Insurance Committee*

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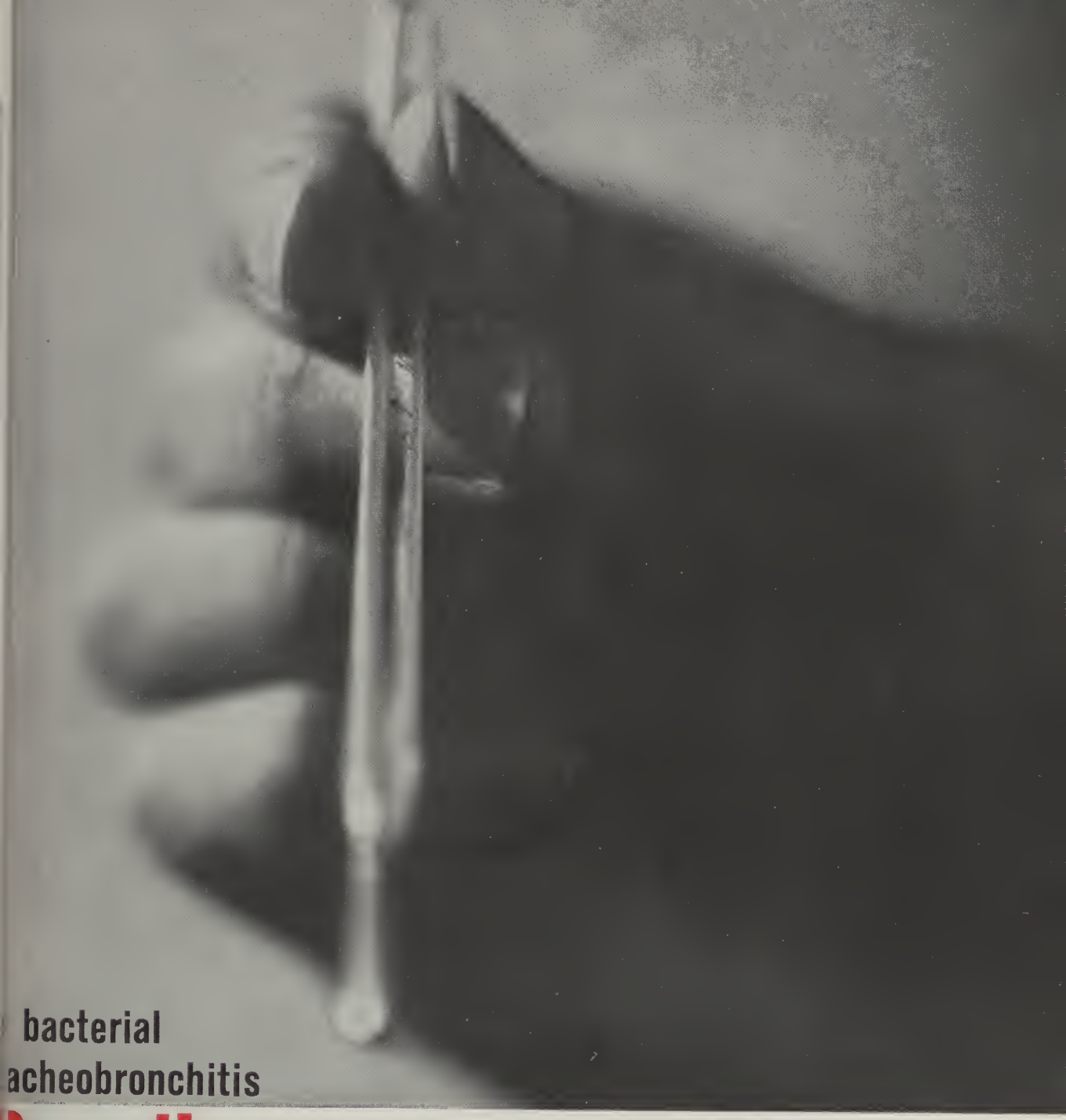


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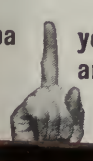


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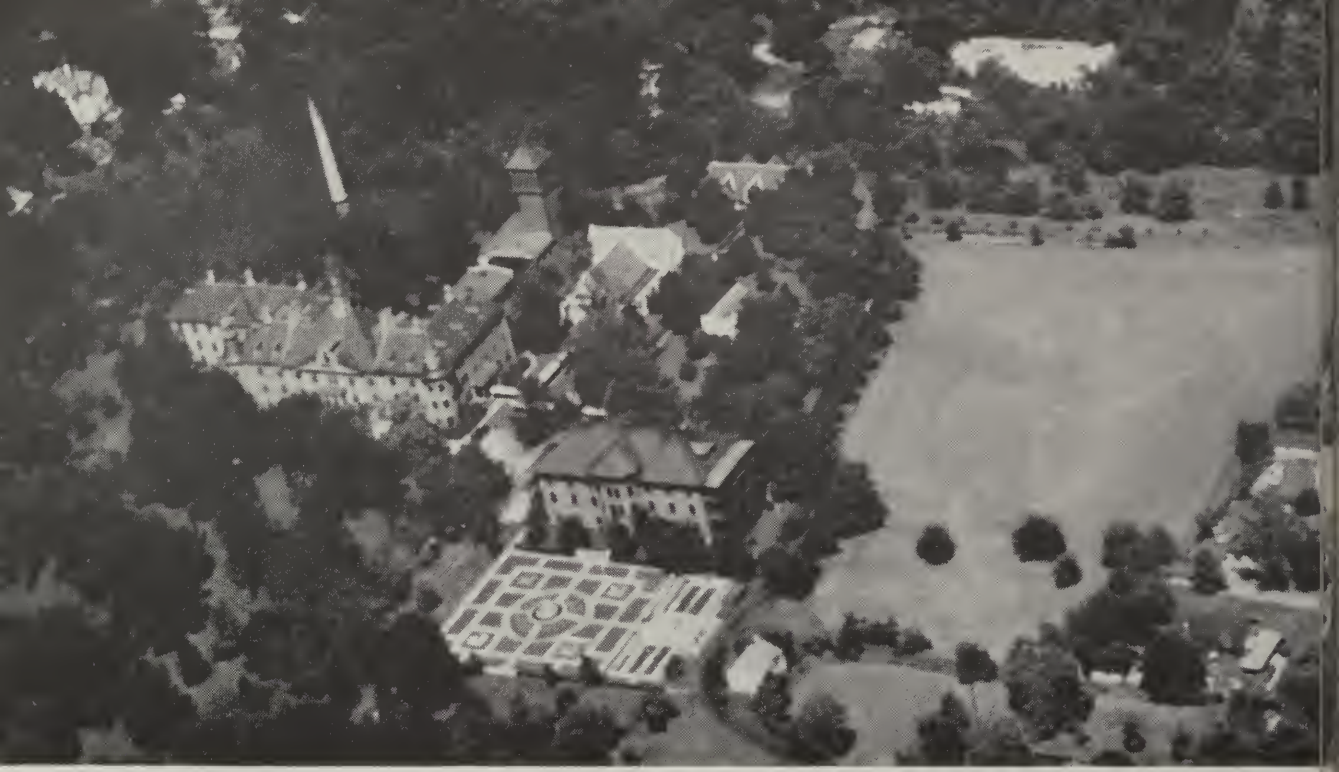
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WASHINGTON NEWS DIGEST



The American Medical Association supported the Kennedy Administration's proposal to provide $750 million in matching funds for construction of medical, dental, public health and osteopathic schools.

In a letter to Sen. Lister Hill (D., Ala.), Chairman of the Senate Labor and Public Welfare Committee, F. J. L. Blasingame, M.D., Executive Vice President of the A.M.A., said:

"As an Association of 179,000 practicing physicians, we are vitally interested in maintaining the high quality of medical education in the United States because of its direct relationship to medical care. For over a century, the American Medical Association has been actively and effectively engaged in the improvement of medical education in the United States. It can now be said, with assurance, that medical education in this country is superior to that found anywhere else in the world. It is a coincidence that the improved standards of medical care in the last half century saw the elimination of sub-standard medical schools and diploma mills which had been turning out graduates in large numbers. This imporvement in medical education is the result of the vigorous efforts of this Association and other interested organizations.

"We strongly believe that increased attention must be given to the adequacy of physical facilities, the availability of qualified instructors and the availability of teaching material and patients for the clinical phases of medical education if high standards of medical education are to be maintained. Any attempt to increase the number of medical students without regard to these conditions will result in a lowering of the standard of medical education. We are of the firm conviction that increase in the physical facilities available for medical education should be given priority at this time over any other federal legislation in the field of medical education.

"We believe that there is need for assistance in the expansion, construction and remodeling of the physical facilities of medical schools and, therefore, a one-time expenditure of federal funds on a matching basis, where maximum freedom of the school from federal control is assured, is justified."

The AMA opposed a provision that might encourage medical schools to expand too rapidly. Doctor Blasingame said: "It is quite possible that a forced increase in freshman enrollment would be detrimental to the quality of medical education."

The General Accounting Office found the Defense Department's Medicare program being conducted generally "in a satisfactory manner," but recommended some changes designed to correct what it considered "important deficiencies."

The Army, which administers the program of medical care for dependents of members of the armed services, took steps to put into effect most of the recommendations of the GAO, which audits federal spending for Congress.

However, Medicare officials rejected a GAO proposal for a change in physician fees.

"Our review disclosed that physicians' claims for medical care are, in general, significantly higher in states where maximum fees are made known to physicians than in those states where maximum fees are not made known," the GAO reported. "We estimate that there is an additional cost of as much as $3 million to $4 million annually as a result of maximum fees, rather than normal fees, being charged in the states where fee schedules are distributed to the physicians."

The GAO recommended that lower fixed fee schedules be negotiated for states where a high percentage of physicians claims are for maximum allowable fees, "subject to being raised only on the basis of clearly supported evidence of higher normal fees."

If lower fees cannot be negotiated, the GAO said, efforts should be made "to have the state medical society or other appropriate parties accept the responsibility for determining that physician claims are generally not in excess of their normal charges."

The GAO further recommended that "physicians be required to certify on each claim that the amount billed does not exceed the physician's normal fee for the medical care furnished."

The Army disagreed, saying that it believed "the present contracting concept is the most suitable to meet the requirements and is in the best interests of the government."

The AMA noted that it had held from the outset that "fixed fee schedules would result in a more expensive program than if physicians were permitted to charge their normal fees."

Fixed fee schedules call for some fees above some so-called normal fees and others below average fees, the AMA said, "physicians tend to 'balance out' by using fees listed in the fixed fee schedule."

Medicare was started December 7, 1960. During the first four years of the program, $130 million was paid to civilian doctors and $133 million to civilian hospitals for care of 1.1 million military dependents. Maternity cases accounted for about half the total.

Medicare has asked Congress for $73.2 million for the fiscal year 1962 beginning this July 1. This is a $6.9 million increase over Medicare's current budget. The increase is needed, Medicare said, because of more military dependents eligible for the program's benefits and increases in the costs of services.

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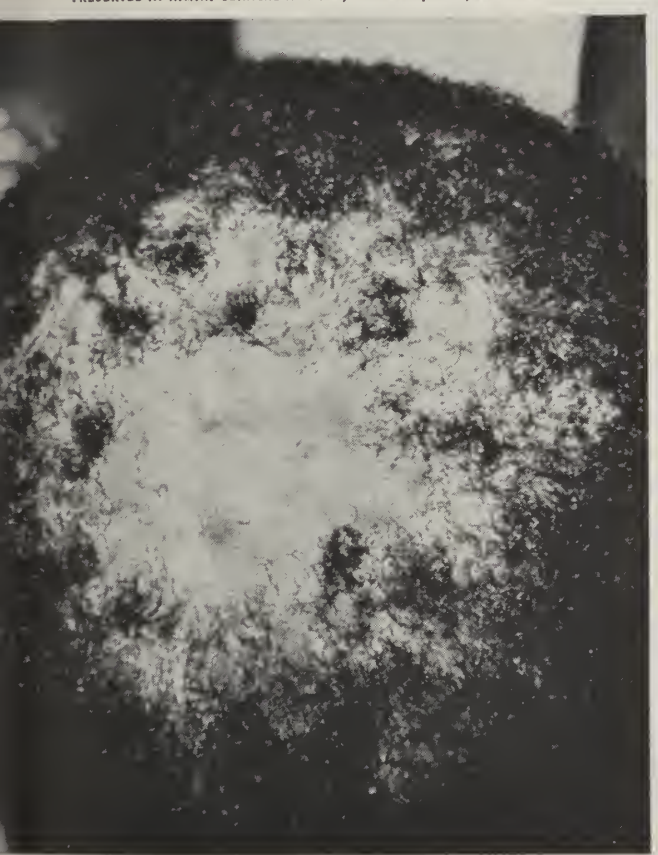
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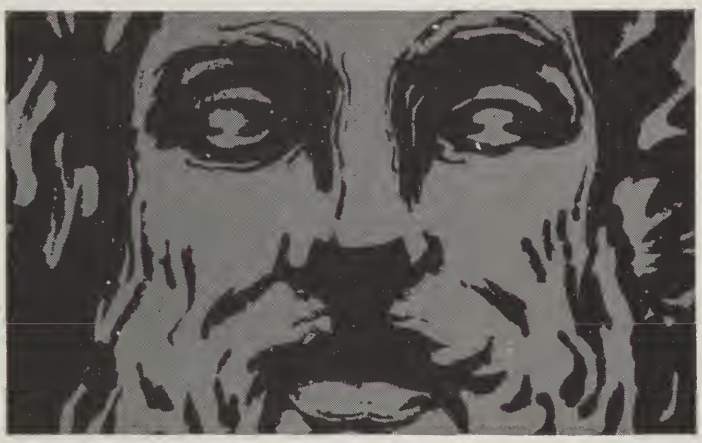
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Practical Application of Pancreatic Function Tests*

WILL W. WARD, JR., M.D.

Louisville, Ky.

Inaccessibility of the pancreas to physical examination requires careful evaluation and selection in the application of available function tests to the diagnosis of pancreatic disease.

THE location of the pancreas in a position relatively inaccessible to physical and x-ray examination makes the diagnosis of pancreatic disease unusually difficult. Diagnosis depends on the clinical history and symptoms, with the assistance of somewhat nonspecific laboratory tests. Unfortunately there is no single comprehensive test to define the functional integrity of the gland, and one is forced to rely on the summation of a number of positive and negative tests.

The pancreas is an organ of both internal and external secretion, but both products are difficult to measure—insulin because of the lack of suitable technique and the exocrine secretions because of the difficulty in obtaining them. Only a small portion of pancreatic tissue needs to be spared from the disease process to prevent the development of diabetes and to provide normal digestion. Definitive diagnosis is further complicated by the fact that the tests, rather than being a measure of the secretory products of the gland, are largely a determination of the effect of these secretions on some other substance and therefore provide only indirect information.

The pancreas normally secretes 500 to 1200 ml. of a colorless, viscous, alkaline (pH 7.0 - 9.0) fluid every 24 hours. This juice contains two proteolytic enzymes, trypsin and chymotrypsin, both in inactive forms; a starch splitting enzyme, amylase, which converts all forms of starch into maltose; and a fat splitting enzyme, lipase, which converts fats to glycerin and fatty acids. The combination of all these elements in a favorable medium is capable of digesting essentially all ingested foodstuffs.

In addition to these digestive ferments, the pancreatic juice supplies a large amount of bicarbonate to neutralize the acid contents leaving the stomach and to provide a favorable alkaline medium for their function The amount and content of the pancreatic secretion is under the control of vagal influences (cephalic phase of digestion) initiated by the presence of food in the mouth and hormonal influences (secretin and pancreozymin) liberated from the mucosa of the duodenum by the entry of hydrochloric acid. Insulin is produced in the islets of Langerhans and secreted directly into the blood stream.

Various disease processes produce their laboratorily detectable changes by some manner of interference in the production and flow

Presented before the Hopkinsville Seminar of the Kentucky Academy of General Practice at Hopkinsville, Kentucky, on November 10, 1960

of these materials to their point of action. Inflammatory changes result from the activation of proteolytic enzymes within the organ itself with subsequent autodigestion of the tissue and blood vessels. This results in the presence of increased amounts of measurable pancreatic enzymes in the blood or the measurable effect of these enzymes on other constituents of blood. Infiltrative and neoplastic diseases result in the gradual replacement of functioning tissue and thus at some point a reduction in the outflow of both exocrine and endocrine secretions. This decrease in secretion can sometimes be measured before the clinical symptoms of impaired absorption and diabetes mellitus appear. Fibrous tissue as a result of previous inflammation may also replace normal tissue and impair secretion. Absence of a sufficient amount of digestive ferments results in the appearance of increased amounts of fecal protein, carbohydrate, and fat, producing the foul smelling, frothy stools of malabsorption states. The islets may remain functionally intact in the face of widespread disease of acinar tissue but when involved, there results some derangement of carbohydrate metabolism, usually hyperglycemia but occasionally hypoglycemia.

Serum Enzyme Tests

A. Serum Amylase: This determination is by far the most important test of acute pancreatitis and/or acute pancreatic injury. Activated pancreatic enzymes diffuse out of the normal duct system into the gland tissue and may further diffuse to the mesocolon, mesentery, and free peritoneal cavity.[1] From these areas the pancreatic fluid is absorbed into the general circulation where it attains a certain level depending on the speed and amount of absorption. Since the enzymes are excreted through the kidney, the blood level will remain high only if there is more absorption than excretion.[2] Within the first 8 hours following the onset of acute pancreatitis, 80% of cases will be found to have a rise in the serum amylase to greater than 250 Somogyi units. After 48 hours this value tends to fall because of gradually diminishing production of pancreatic enzymes, even though there may be clinical evidence of continuing pancreatitis. A positive serum amylase (greater than 250 units) signifies acute disease of the pancreas and in fact, is necessary before the diagnosis of acute pancreatitis can be established.

On occasion an elevation of the serum amylase may be found under other conditions. Acute inflammation of the salivary glands can cause release of an amylase (ptyalin) into the blood stream which is indistinguishable from pancreatic amylase.[3] However, parotitis is usually obvious and doesn't enter into the differential diagnosis of diseases of the upper abdomen. Disease of the biliary tract, usually a stone at the ampulla of Vater, high intestinal obstruction, and perforation or penetration of a dudodenal ulcer may cause an elevation of the amylase through increasing the pressure under which it is secreted or by allowing it to spill out into the peritoneal cavity where it can be absorbed. Values in these situations are usually far below the 500 to 1000 units (Somogyi) found with acute pancreatic inflammation.[4] The amylase may be elevated due to retention in terminal uremia, though this is not uncommonly associated with pancreatitis. The reported elevation following morphine injections is slight and of no practical significance.

B. Serum Lipase: The elevation of the serum lipase with acute pancreatic disease depends on the same physiological changes as the amylase. This is elevated above 2.0 units (Cherry-Crandall) in about 50% of cases, beginning at about 48 hr. and declining over 7 to 10 days. It merely lends support to the serum amylase test.

C. SGOT: This test is useful in assessing pancreatic function in a negative sense. Its elevation in an upper abdominal crisis points away from acute pancreatic disease and toward hepatic or myocardial disease.

D. Measurement of Amylase in other Fluids: Pancreatic enzymes may be measured in the urine. The rise in urinary amylase may be more prolonged than that in blood (normally 200 to 1000 units). Lipase is not measured in the urine because of technical difficulties. The only time measurement of urinary amylase would have any practical application would be in the evaluation of a bout of abdominal pain two or three days after its occurrence. Pancreatitis may result in pleural effusion and pulmonary parenchymal abnormalities,[5] and the amylase determination in this fluid may occasionally prove helpful. The pancreatic ferments ap-

parently reach the pleural fluid via transdiaphragmatic lymphatic channels.[6]

E. Other enzymes: A wide variety of other enzymes has been introduced into the evaluation of liver, biliary tract, and pancreatic disease. These enzymes include isocitric dehydrogenase, 6-phosphogluconic dehydrogenase, glutamic pyruvic transaminase, hexose isomerase, cholinesterase, lactic dehydrogenase, ceruloplasmin, 5-nucleotidase, malic dehydrogenase, trypsin, and aminotripeptidase.[7] These are of little practical use for our purposes because of either the technical difficulty involved in the performance of the determinations or the rather inconsistent and varying results in various clinical situations. The serum cholinesterase is generally depressed with any malignancy and is said to be about 85% accurate in predicting whether obstructive jaundice is due to a benign or malignant lesion.[8] The determination of serum leucine aminopeptidase has been shown to be no more accurate than the alkaline phosphatase in differentiating benign from malignant obstructive jaundice.[9]

Lactic dehydrogenase activity of human plasma has recently been shown to consist of the sum of the activity of five isoenzymes. Alteration of this isoenzyme pattern is thought to be a more accurate and prolonged indicator of myocardial necrosis than the measurement of total lactic dehydrogenase, glutamic oxalacetic transaminase, aldolose, or malic dehydragenase activity. Total lactic dehydrogenase has been shown to have a characteristic pattern depending on whether it is derived from pancreas, liver, skeletal muscle, spleen, or kidney. The measurement of the isoenzyme alterations may soon prove to be the most accurate mirror of specific organ necrosis and disease.

Stool Examination

Pancreatic enzymes are present in feces but difficult to examine because they can not be separated from other digestive enzymes. In the case of children a fecal suspension can be made and placed on gelatin film. The extent of removal of gelatin gives some indication of the amount of tryptic activity of the stool.[11] Stools develop characteristic changes in the absence of pancreatic enzymes, whether it be due to obstruction of flow into the duodenum or deficiency of secretion. Usually they become bulky, of putty-like consistency, pale in color, and have a rancid odor. The bulk is contributed by undigested carbohydrate and the foul odor by undigested fat and protein. On microscopic examination, numerous meat fibers are found and, after appropriate staining, fat droplets may be seen.

X-Ray Examinations

A. Plain Film of the Abdomen: Diffuse calcification in the area of the pancreas is nearly always a sign of chronic pancreatitis and is therefore a simple method to help evaluate pancreatic function.

B. Upper Gastrointestinal X-ray: This examination may give some idea of whether a space occupying lesion is present in the pancreas by showing an increase in size or a widening of the duodenal loop.

C. Intravenous Cholangiogram: This examination has been reported to be helpful in differentiating acute pancreatitis from acute cholecystitis. In the presence of acute cholecystitis, visualization of the biliary duct system is accompanied by failure to visualize the gall bladder, while in the presence of acute pancreatitis, visualization of the biliary duct system is accompanied by gall bladder visualization. Failure of both to visualize is of no benefit in the differential diagnosis.[12]

Glucose Metabolism

Hyperglycemia is frequently associated with pancreatic disease. Hyperglycemia should be considered present when the fasting true blood sugar is above 100 mgm. %. The blood sugar curve following 100 gm. of glucose given orally should be considered "diabetic" when the peak blood sugar is greater than 160 mgm.% (usually at 1 hr.) and the 2 hr. value remains above 120 mgm.%. Transient hyperglycemia is extremely common during bouts of acute pancreatitis. In chronic pancreatitis frank diabetes occurs in 10 to 15% of cases while an impaired glucose tolerance test is present in 75%. A diabetic curve will be found on glucose tolerance testing in 25% to 80% of patients with carcinoma of the pancreas depending on the series quoted.[13] A fasting hypoglycemia (true blood sugar levels below 50 mgm%) is characteristically produced by insulin secreting adenomas. Hypoglycemia is quite uncommon with chronic pancreatitis but

occasionally occurs. This is apparently due to hyperplasia of the islets which are usually spared during the destructive process of acute pancreatitis.[14]

Absorption Studies

Most studies of intestinal absorption other than the stool examination are fairly involved. The routine oral glucose tolerance test is a very gross evaluation of absorption as well as the insulin producing capabilities of the pancreas. A delay in peak blood sugar values to two hours or beyond and/or a rise of less than 40 mgm% above the fasting value is indicative of some error in intestinal absorption. The D-xylose absorption test is the simplest examination to perform to help differentiate pancreatic insufficiency from other forms of malabsorption. This test consists of giving the fasting subject 25 gm. of D-xylose and measuring the urinary output during the ensuing 5 hour period. It is a more accurate test than the oral glucose tolerance test and is found to be normal (5 to 7 gm. excreted) in malabsorption states due to pancreatic disease, while it is definitely abnormal (less than 2.5 gm. excreted) in the presence of steatorrhea due to other causes.[15]

Another method of studying intestinal malabsorption states, and attempting to evaluate whether they are due to pancreatic insufficiency, is by measuring radioactivity in blood or stools following the administration of I^{131} labeled triolein and oleic acid. Pancreatic lipase is necessary to break down the triolein into fatty acids for absorption. In cases of poor absorption due to intestinal disease there is an increased amount of radioactivity in the stools following administration of both triolein and oleic acid. However, in pancreatic disease states producing malabsorption, there is an increased radioactivity in stools only after ingestion of the labeled triolein, since pancreatic enzyme is necessary for its proper absorption but not for absorption of oleic acid. By a similar method, one may measure plasma or stool radioactivity of I^{131} labeled fatty meals given with and without pancreatic extracts to see whether there is greater absorption when pancreatic extracts are administered.[16] For practical purposes the status of the pancreas may be evaluated by giving the patient 10 to 20 gm. of pancreatic extract daily in divided doses and observing for a decrease in the steatorrhea.

Other Tests

There are further tests of pancreatic function but in general these are difficult in technique or interpretation and should be left in the hands of those who perform them on large numbers of patients. Very briefly these include:

1. Various tests of coagulation which attempt to measure the effect of released trypsin on the coagulation mechanism.
2. Retroperitoneal insufflation of air in an attempt to visualize pancreatic size and shape.
3. Examination of duodenal contents before and after pancreatic stimulation with secretin.
4. Measurement of serum enzymes before and after stimulation of the pancreas by secretin and vagotonic drugs.
5. Comparison of blood sugar curves after starch and after glucose meals.

Summary

In summary it must be said that there is no good, single test to assess the functional capacity of the pancreas. The serum amylase most closely approaches this in the evaluation of acute pancreatic inflammation. Some idea of pancreatic condition and function can be gained by weighing the information gathered from a number of tests selected on the basis of whether the symptoms suggest acute or chronic pancreatic disease. The most practical and useful of these are:

1. Measurement of serum enzymes
2. Stool examination
3. Flat film of the abdomen and upper gastrointestinal x-ray
4. Glucose tolerance test
5. Absorption test or trial on pancreatin.

Considerable aid in diagnosis may be obtained from the proper interpretation of the information gathered from these various methods of testing pancreatic function.

(References on Page 715)

Surgical Considerations In Occlusion Of The Superior Mesenteric Artery

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Diagnosis of mesenteric infarction requires a high index of suspicion. Survival depends upon prompt diagnosis, adequate collateral circulation, and appropriate surgical intervention.

As life expectancy increases, vascular problems occupy a more eminent place in the sphere of abdominal emergencies. An appraisal of some of these vascular crises reveals that they do not have to be faced with a dismal outlook. Vascular surgery has evolved into a useful clinical tool. However, unless reconstruction is applied to stenotic lesions and mesenteric vessel occlusion before gangrene occurs, the results will remain poor.

The mortality rate of mesenteric infarction is approximately 94 per cent.[5] The incidence of mesenteric vessel occlusion is about equally divided between arterial and venous obstructions. Regardless of the nature of the obstruction, the process terminates as hemorrhagic infarction in 98 per cent of the cases.[22] Venous occlusion is usually secondary to increased coagulability of blood in peritoneal infection, cirrhosis, carcinoma, trauma, or blood dyscrasias. In small bowel infarction without venous obstruction, 60 per cent of the cases are due to emboli to the superior mesenteric artery, and 20 per cent stem from arteriosclerotic thrombosis of the superior mesenteric artery and its branches. However, in the remaining 20 per cent there is no evidence of occlusion of the arterial supply to the bowel. Heart failure and concomitant shock are often prominent features in infarction without demonstrable occlusion.

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Acute Mesenteric Artery Occlusion

Embolism to the superior mesenteric artery occurs forty times more frequently than that of the inferior mesenteric artery. The larger internal diameter of the superior mesenteric artery and its parallel course with the aorta appear to account for the more frequent occurrence of emboli to this vessel. Emboli tend to lodge at the level of the middle colic and the second jejunal branches of the superior mesenteric artery.[3] The heart provides the source for emboli in 86 per cent of the cases, while degenerating aortic plaques account for the remainder. In contrast, thrombosis occurs within 2 to 4 cm. of the ostium of the superior mesenteric artery in approximately two-thirds of the cases.

The effects of occlusion of the superior mesenteric artery depend upon the abruptness of the obstruction and the collateral circulation to the area involved. Gradual occlusion gives the collateral channels an opportunity to develop. Since there is no marginal artery along the small intestine, the collateral circulation is frequently inadequate. The mid gut, however, has a great revascularizing potential from its vast intramural connections.[15] The collaterals are derived from the left colic, superior pancreaticoduodenal, 12th intercosal, and lumbar arteries.

Distal to the occlusion the blood pressure is reduced to about one-third normal.[10] Spasm develops, which tends to propagate the clot. After eight to ten hours of total arterial occlusion, there is splotchy hemorrhagic in-

farction. This is the usual sequence of events, although variations occur.

Occlusion at the mouth of the superior mesenteric artery usually results in infarction from the ligament of Treitz to the mid transverse colon. Obstruction at the middle colic and second jejunal branches tends to produce gangrene from the proximal eighteen inches of the jejunum to the hepatic flexure of the colon. Ileocolic arterial occlusion frequently terminates in necrosis of the cecum and distal six or eight inches of the ileum. Unless a vas rectum is occluded, other sites of compromise in the bowel circulation do not consistently produce infarction.[2]

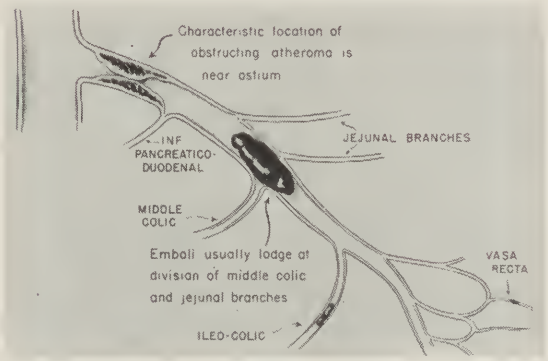


Figure 1
Location of Lesions

A prompt, correct diagnosis is most dependent upon a suspicious mind. The symptoms are usually disproportionate to the physical signs. Excruciating abdominal and back pains, associated with heart disease or a history of emboli to other organs make a diagnosis of superior mesenteric artery embolism most tenable. Abdominal tenderness and rigidity become manifest only in the terminal phase of the disease. The palpation of a mass is the exception. The patient tends to be hypothermic. Peristalsis is usually hyperactive within the first eight hours and thereafter the abdomen is silent. Melena is recorded in about one-third of the cases. Marked leukocytosis is evident in about 60 per cent of the cases after six hours of occlusion. Flat films of the abdomen reveal no pathognomonic features. Early in the disease there is a paucity of gas in the bowel. Late in the course of infarction, the gaseous distention simulates mechanical obstruction.

Frequently abdominal paracentesis yields a blood-stained fluid. A short bevelled #20 needle is selected for tapping. A larger number of positive taps will be obtained from careful aspiration of all abdominal quadrants. Blood-stained fluid demands surgical exploration; however, bloody fluid usually means that gangrene is already present.

Absolon has reported the use of radioactive iodinated serum albumin for measuring intestinal blood flow. This test appears to have the most promise as a diagnostic aid.[1] A variety of enzyme elevations and pigments in both blood and urine have been reported, but they appear to be non-specific or occur so late that they are of little value for diagnosis.[8]

Treatment

The survival of patients with acute major superior mesenteric artery occlusion is dependent upon the collateral circulation of the bowel, prompt diagnosis, and early surgical intervention.

The superior mesenteric artery down to the middle colic branch is approximately 1 cm. in diameter and is roughly comparable to the common femoral artery. Reconstructive procedures can therefore be undertaken with some chance of success.[14]

Restorative operations include embolectomy, thromboendarterectomy, by-pass graft with a plastic prosthesis or splenic artery, or limited resection combined with some type of reconstructive procedure. A limited area of infarction is probably best handled by resection and anastomosis rather than attempting any type of reconstructive procedure. However, in the face of extensive arterial occlusion, reconstruction should always be attempted for it may be possible to salvage much of the bowel or prevent the development of an anastomotic fistula.[20]

The method of correction would depend on what is found at laparotomy. Ischemia of the mid gut is deceptive and the abdomen may be closed by the unsuspecting surgeon, only to find massive gangrene at autopsy. The bowel is usually pale gray and rippled in the early hours of occlusion. Palpation of the origin of the superior mesenteric artery and incision of a vas rectum will provide proof of the arterial circulation. In venous obstruction, the diagnostic problem is not so challenging for the mesen-

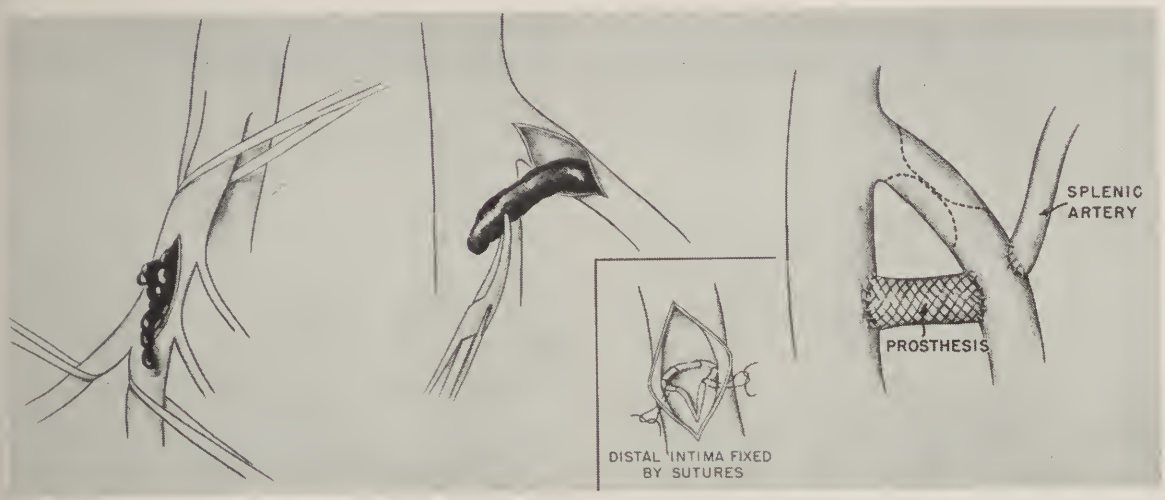


Figure 2
Types of Corrective Operations

tery and bowel present a picture of a thickened, soggy organ dripping bloody transudate.

Once it is clear that an arterial obstruction exists, the proximal eighteen inches of the jejunum should be observed. If the vasa recta in this area are pulsating and the adjacent bowel appears viable, the obstructing agent is most likely an embolus lodged at the middle colic artery. This area is most easily approached by a longitudinal incision in the root of the mesentery medial to the ligament of Trietz. This is the infra-colic approach to the superior mesenteric artery. A cephalad propagating thrombus from an embolus lodged at the middle colic artery may produce ischemic changes to the ligament of Trietz but the proximal jejunum may be viable even though the remaining mid gut is necrotic. If the bowel appears to be equally involved as far as the ligament of Trietz, the obstruction is probably an arteriosclerotic thrombus at the mouth of the artery. This region is most satisfactorily approached through the gastrocolic ligament. The history may be a guiding factor in determining whether an infra or supra colic approach is the most desirable. This exposure is somewhat tedious in view of the superior mesenteric sympathetic plexus.

I favor a longitudinal arteriotomy. Following an endarterectomy, the distal intima must be sutured to the media to prevent subsequent dissection. If back flow from the distal vessels is absent or minimal, Shaw recommends gentle milking of the mesentery after mobilization of the right colon.[6] All clot proximal and distal to the arteriotomy must be removed. However,

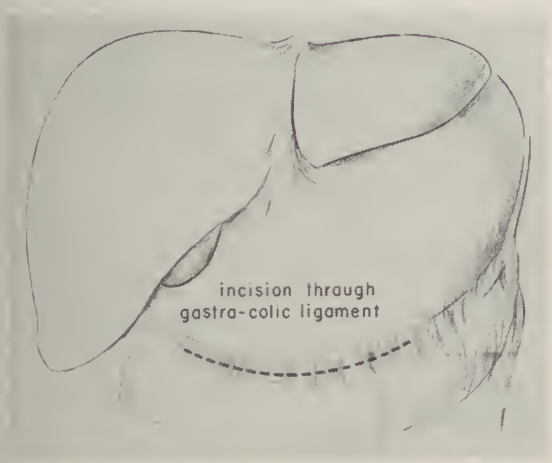


Figure 3

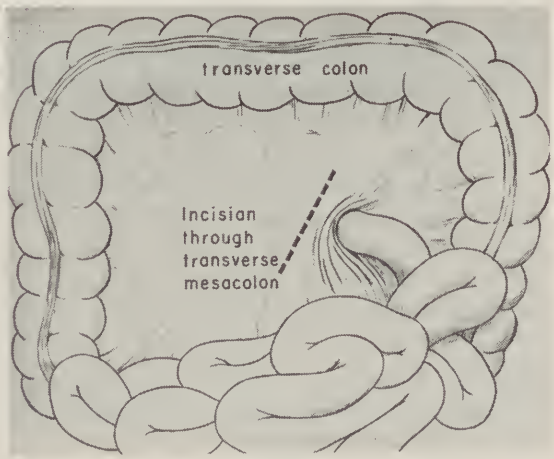


Figure 4

Surgical Approaches to Superior Mesenteric Artery

the retrograde flushing technique so commonly employed in the extremities has not proven technically feasible.

Gangrene

At the end of twenty-four hours, the patient should be re-explored to see if patchy areas of gangrene are present or the process has progressed. Six out of eight surviving cases thus far reported have required segmental resection or plication of the intestines.[14, 17, 18, 19, 21, 23] Perhaps with the diagnosis of superior mesenteric artery obstruction before eight hours of total occlusion, the second laparotomy can be avoided. But in all cases in which the initial insult occurred at least eight hours before attempted reconstruction, the second laparotomy is definitely indicated.

The nearer to gangrene the bowel is at the time of reconstruction, the greater will be the edema in the postoperative period. Absolute rest of the bowel must be enforced or gangrene will supervene, even though the circulation is restored. Supportive measures in the postoperative period must include effective intestinal decompression, antibiotics and anticoagulants.

Gangrene without evidence of obstruction is apt to occur in the old age group following progressive symptoms of congestive heart failure and borderline shock. Actually no blood reaches the intramural vessels. The symptoms of shock and superimposed congestive failure may be present for days or weeks before actual infarction supervenes. Abdominal exploration may disclose gangrene of the entire gastrointestinal tract from the stomach to the rectum. Patients in this category treated with vasopressor drugs during the period of shock, develop hemorrhagic infarction more rapidly from shunting of the mesenteric circulation.[4, 7]

If impending gangrene is apparent and there is no evidence of obstruction after dissection of the superior mesenteric artery, supportive measures should be directed toward increasing the cardiac output and maintenance of intestinal blood pressure. Digitalization, oxygen, splanchnic block,[16] intestinal decompression, antibiotics, local intra-arterial Xylocaine®, and anticoagulants are suggested.

The presence of melena must be interpreted as ischemic necrosis of the mucosa. Destruction of the mucosa implies features of endotoxin shock which are probably best combatted by steroids.[11]

If massive gangrene is encountered at laparotomy, the only choice is extensive resection. Patients have survived following resection of fifteen to twenty feet of bowel, but they are plagued with diarrhea, avitaminosis, tetany, weight loss, and generalized deterioration. Therefore, an aggressive attitude should be maintained toward early diagnosis of acute mesenteric occlusion. Reconstruction can only be carried out with success if the bowel is viable at the time of exploration.

The prognosis tends to be better if the embolus is secondary to rheumatic heart disease. Emboli from the arteriosclerotic heart or atheromatous thrombosis of the superior mesenteric artery carry a higher mortality. The underlying disease process is diffuse and deterioration of other organ systems are apt to complicate the outcome. This is especially true of the cardiovascular system.[9]

Chronic Mesenteric Artery Occlusion

Patients with arteriosclerotic stenosis of the mouth of the superior mesenteric artery often give a history of abdominal pain and gas after a heavy meal, weight loss, and three or four bulky stools a day. The patient soon learns to eat only light food in order to avoid post-prandial periumbilical crampy pains. The picture of a chronic illness in an underweight individual is typical. The stool will occasionally show positive reactions for occult blood. These symptoms suggest that the superior mesenteric artery is about 80 per cent occluded. Approximately one-third of the patients who progress to occlusion will relate a history suggestive of partial obstruction. These patients frequently have other signs of arteriosclerosis such as absent or diminished pulses in the extremities. Any systemic problem which lowers the blood pressure may initiate gangrene of the bowel.[12,13] Translumbar or retrograde aortography will be necessary to make a definite diagnosis. A left thoraco-abdominal incision will provide excellent exposure of the origin of the superior mesenteric artery.

Special attention should be paid this group of patients with abdominal claudication for the natural history of this process is terminal in-

farction. The optimum time for reconstruction of the superior mesenteric artery is before the occlusion is complete.

Summary

Survival in superior mesenteric artery occlusion appears to reside with prompt diagnosis, collateral circulation, and appropriate surgical intervention. The mortality should improve if reconstruction is undertaken prior to the onset of visceral gangrene. The patient will require constant support throughout his hospitalization for many organ systems appear to be involved or affected by occlusive vascular disease.

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Occult Blood Loss in Iron Deficiency Anemia of Infancy

Significant amounts of occult gastrointestinal blood loss were seen in 13 infants with iron deficiency anemia; radio-iron was used as a tracer. The radio-iron was administered intravenously. The red cell and fetal radioactivity was measured for the following 3 to 4 weeks. The percentage of total Fe^{59} administered recovered in the stool varied between 0.75% and 16.4% with a mean of 5.75%. This represented a loss of whole blood in the stool varying from 7 to 107 ml. during the observation period. The children were aged 7 to 17 months; the extent of their anemia was indicated by a loss of from 4.1 to 10.2 grams per 100 ml. Two normal children lost .73% and 1.96% of red cell radio-iron in the stool, representing 4 and 12 ml. in comparable periods.

—M. S. Hoag, R. O. Wallerstein, and M. Pollycove, Pediatrics, Vol. 27:199 (Feb.) 1961

Pulmonary Decortication

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The physiological restoration of bodily function is well exemplified in the surgical procedure of decortication. The surgeon is able to rehabilitate what has heretofore been considered an irreversible and crippling pulmonary disease.

THE surgical procedure of freeing a captured or imprisoned lung in order to obliterate an abnormal pleural space and re-expand the underlying lung was, up until World War II, an essentially unsolved problem. Fowler, in 1893, and Delorme independently in 1894, were the first to attempt the procedure of decortication of the lung. Their cases were those of chronic empyema and it is not surprising that their results were unsatisfactory, due to inadequate ancillary procedures. Without effective methods of controlling infection, adequate anesthesia and adequate blood replacement, a satisfactory and safe procedure could not be developed.

It was not until World War II when Churchill, Burford, Parker and Samson repioneered the field that a rational and effective method of treating posttraumatic infected hemothorax was presented. Following their work many others, both in civilian and in military practice, carried out the same or similar procedures with excellent results.

The purpose of decortication at the present time is that of the elimination of abnormal pleural space, the re-expansion of the underlying lung and the re-establishing of normal pulmonary function and chest wall motion regardless of the antecedent cause of the abnormality. The basic indication for decortication is to achieve this result. The conditions requiring or best treated by decortication can be further subdivided into the following categories:

1. Empyema
   - acute
   - chronic
2. Hemothorax
   - non-infected
   - infected
3. Persistent Pleural Space
   - secondary to old pneumothorax
   - secondary to effusion

This classification can be further subdivided into tuberculous, non-tuberculous and, in selected instances, malignant underlying causes. For the purposes of this paper the discussion will be limited to the non-tuberculous category. Under category number one can be included cases of acute and chronic empyema which may be secondary to pneumonia, lung abscess, bronchiectasis and staphylococcus pneumonia, which is a frequent precursor of an infected pleural effusion in infants. Category number two includes hemothorax subsequent to penetrating, perforating or closed injuries to the thorax or undiagnosed causes of hemothorax. Category number three is self explanatory.

Case Reports

The following case reports are illustrative of several of the more common indications for decortication from infancy to adulthood at the present time.

Case No. 1 (RM)—This six-year-old child developed upper respiratory tract infection characterized by fever and symptoms of cough, dyspnea and cyanosis sixteen days prior to ad-

mission to the hospital. Physical examination revealed narrowed interspaces on the left, scoliosis with concavity to the left and diminished to absent breath sounds on the left. Chest x-ray on admission revealed loculated pleural effusion on the left with suggestion of cavitation in the left lower lobe. Thoracentesis yielded a small amount of straw colored fluid from the left hemithorax. The operation performed was a left thoracotomy with findings of lung abscess in the superior dorsal segment of the left lower lobe with large empyema space and pleural peel. A superior dorsal segmentectomy was accomplished with decortication of the parietal and visceral pleural surfaces with immediate complete re-expansion of the remaining lung tissue. Pathology revealed a pulmonary abscess with chronic pneumonitis and fibrinous pleural peel. The postoperative course was uncomplicated, with discharge on the seventh postoperative day. X-ray examination on the day prior to discharge revealed complete re-expansion of the lung, with straightening of the previously noted scoliosis and normal position of the ribs on the operative side. Followup examination revealed normal pulmonary findings one year later with no evidence of scoliosis or any evidence of respiratory difficulty.

Case No. 2 (WW)—Admission diagnosis: Pneumonia with pleural effusion, right side. This five-year-old patient had developed pneumonia approximately four weeks prior to admission which had been treated with antibiotics with improvement. Symptoms recurred a few days prior to admission with marked pleural effusion on the right. Thoracentesis revealed a purulent effusion with Staphylococcus. Due to inability to remove the effusion completely with thoracenteses, a right thoracotomy was performed on June 10, 1959 with evacuation of massive amounts of infected material plus the removal of the parietal and visceral pleural peel. The postoperative course was uneventful other than slowness in re-expanding the right lung requiring repeated tracheal suction. The lung has re-expanded well since, with some elevation of the right diaphragm and some thickening of the pleura laterally. There was minimal scoliosis at six months postoperative with normal growth of the chest bilaterally.

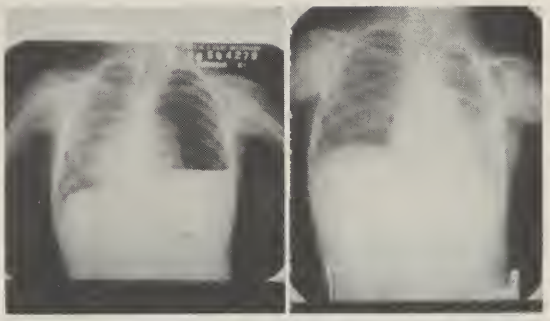


Figure 1
Preoperative and postoperative films. See Case No. 3 (DO).

Case No. 3 (DO)—This four-year-old patient was admitted to the hospital with a history of pneumonia in March 1959. This was followed by pleural effusion treated by repeated thoracenteses. The fluid continued to form; therefore, the patient was transferred for definitive treatment. A left thoracotomy was performed, removing approximately 100 cc. of purulent material. There was a thick fibrous peel present over the visceral surface of the lung as well as a somewhat thinner peel over the parietal pleura. This was completely removed, revealing a normal appearing underlying lung and pleura of the chest wall. The diaphragmatic surface was freed as well. The patient was discharged from the hospital on the seventh postoperative day. Followup examination three months postoperatively revealed complete expansion of both lungs. At that time there were no complaints and no signs of any abnormality as far as the respiratory system was concerned. The patient has been lost to further followup.

Case No. 4 (HS)—This patient was admitted to the hospital due to the presence of empyema on the left. This had not responded to thoracentesis. The patient was progressively deteriorating and consequently was transferred to the hospital here for definitive therapy. A left thoracotomy with evacuation of the empyema content and decortication of the parietal and visceral pleurae was accomplished. Approximately 1,000 cc. of purulent fluid were removed. The peel measured one half to three quarters of an inch in thickness. The underlying lung following decortication had a normal appearance. The patient's immediate postoperative course showed dramatic improvement with an afebrile course and discharge on the seventh postoperative day. He subsequently de-

veloped a small stitch abscess on two occasions, both of which responded immediately to removal of the suture. Respiratory function since operation has been normal although the left diaphragm was adherent to the left lateral chest wall quite high.

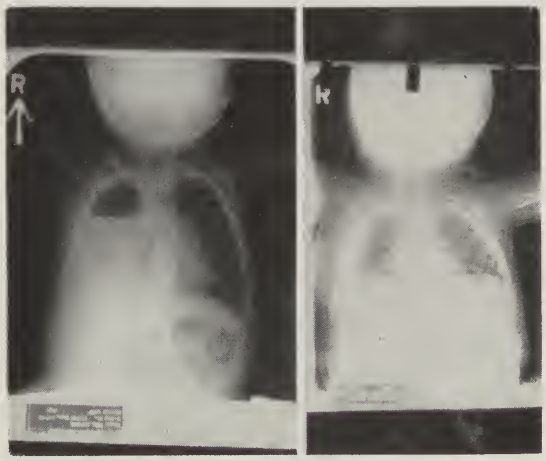


Figure 2
Preoperative and postoperative films. See Case No. 5 (MB).

Case No. 5 (MB)—This six-month-old papatient was admitted to the hospital with a history of Staphylococcus pneumonia. Twenty-four hours after admission, chest x-ray revealed a large pneumatocele on the right which ruptured within a period of three days causing a pyopneumothorax on the right. The patient was treated for several days with intensive antibiotic therapy and tube drainage with no improvement in the pneumothorax although the patient's general physical condition improved markedly. Due to the continued presence of a pneumothorax, thoracotomy and decortication were undertaken, with removal of a thick peel over the parietal and visceral pleural surfaces. The area of rupture of the pneumatocele was not decorticated. The patient was discharged from the hospital seven days postoperatively. The only complications were several small stitch abscesses which healed promptly with removal of the underlying subcutaneous suture. A followup chest x-ray one month postoperatively (see photograph) revealed an essentially normal right lung and diaphragm.

Comment: The preceding five cases are typical examples of acute empyemas in age range of six months to forty years treated by decortication.

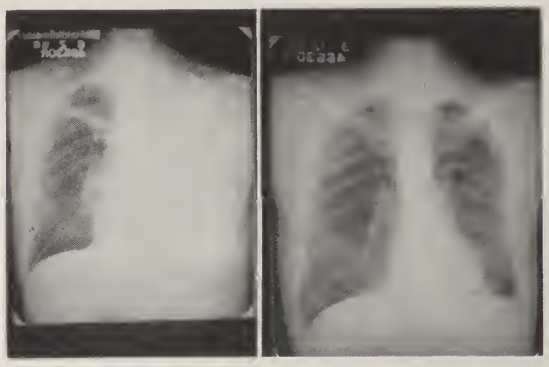


Figure 3
Preoperative and postoperative films. See Case No. 6 (LK).

Case No. 6 (LK)—This forty-seven-year-old male developed a hemothorax on the left following an automobile accident with multiple rib fractures on the left. Repeated thoracenteses failed to completely re-expand the left lung. An open thoracotomy was performed on August 4, 1956 with removal of the clotted hemothorax and decortication of the fibrothorax. The patient's postoperative course was uneventful and chest x-ray obtained approximately six months postoperatively showed complete re-expansion of the left lung. Fluoroscopy revealed good motion of the diaphragm as well as the chest wall despite the obvious deformity due to the multiple rib fractures.

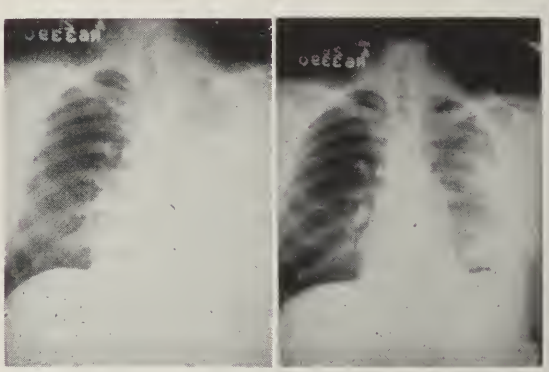


Figure 4
Preoperative and postoperative films. See Case No. 7 (RT).

Case No. 7 (RT)—This patient was seen at the hospital following a stab wound of the chest. There was moderate pleural effusion on the left. This was treated for several days by thoracenteses with an apparent seventy-five per cent re-expansion of the left lung. Probably due to false expansion effusion then suddenly increased in amount, necessitating emergency thoracotomy on the left. Approximately 3,000

cc. of old blood and clot were evacuated. There was a thick peel present over the visceral and parietal pleurae which was removed. Following this, standard thoracotomy tube drainage was carried out for a period of four days; the tubes were then removed with complete re-expansion of the left lung. The patient was discharged from the hospital on the seventh postoperative day. Followup examination revealed normal left hemithorax with good diaphragmatic function. There was no evidence of deformity of the chest wall.

Comment: The preceding are examples of uninfected hemothorax. It is interesting to note that in both of these cases early surgical intervention was necessary due to increasing effusion. In this type of case it is important not to perform tube drainage because this will invariably convert these to infected cases.

Case No. 8 (JC)—This patient sustained an injury several weeks prior to admission for thoracotomy. Treatment consisted of repeated thoracenteses and bedrest with appropriate antibiotics. Fluid continued to form, leading to the decision for thoracotomy. The patient was transferred to the hospital here and thoracotomy performed with the removal of large amounts of purulent fluid and decortication of the middle and lower lobes. The postoperative course was uneventful and the patient was discharged from the hospital on the ninth postoperative day with ninety-five per cent re-expansion of the right lung. Further evaluation since discharge revealed no significant abnormality of the right hemithorax.

Case No. 9 (RG)—This patient had been treated for two stab wounds of the right hemithorax in the Emergency Room of the hospital with no chest x-ray obtained. Approximately one month later he was re-admitted to the hospital with findings of a massive empyema on the right. Right thoracotomy and decortication were performed, removing two liters of purulent material. A very thick parietal peel and visceral peel were encountered, measuring up to one half inch in thickness. These were removed, with good re-expansion of normal appearing lung. The chest was then closed, utilizing two thoracotomy drainage tubes which were removed on the fourth postoperative day. Following discharge from the hospital the patient developed a small chest wall abscess in the line of the incision which required subsequent local drainage. The lung has since re-expanded well with some thickening of the pleural surfaces on the right. There is continuing resolution of this pleural thickening with no evidence of recurrent infection. Pulmonary function continues to improve.

Comment: The preceding two cases are typical infected hemothoraces requiring decortication.

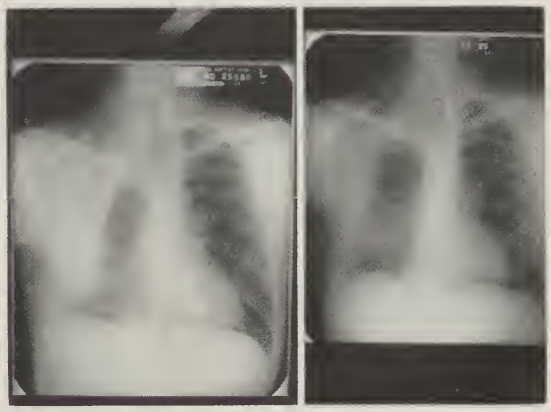


Figure 5
Preoperative and postoperative films. See Case No. 10 (HM).

Case No. 10 (HM)—This patient sustained a gunshot wound of the right hemithorax seventeen years prior to examination. X-ray revealed a markedly thickened and calcified plaque completely binding down the right lung with marked deformity of the right hemithorax due to its inability to expand and grow during the patient's adolescent years. A bronchogram revealed a normal underlying right bronchial tree. A right thoracotomy and decortication were performed with marked technical difficulty due to the firm adhesions between the chest wall and the plaque as well as the lung and the overlying plaque. On removal of the thickened plaque which measured up to 3 cm. in total thickness with two calcified layers measuring 5-6 mm. in thickness, the underlying lung appeared normal and expanded well. The postoperative course was uneventful with evidence of motion of the chest wall and re-expansion of the underlying lung within seven days postoperatively. The patient was discharged from the hospital well seven days postoperatively. Comparative chest measurements over a period of five months postoperatively have shown a 5 cm. increase in AP diameter of the right hemithorax. The difference in AP diameter of the two hemithoraces is now less than 3 cm.

The former obvious deformity is now inapparent except on close examination and subjectively the patient's pulmonary function is markedly improved.

Comment: This case is one of the chronic healed empyema that is particularly interesting due to the long interval, i.e., seventeen years, from onset of disease to definitive therapy.



Figure 6
An example of an untreated hemothorax. Note complete destruction of lung with severe bronchiectasis. Compare with Case No. 10 in which intervention was accomplished prior to lung destruction.

Prior to the development of pulmonary decortication the only methods of therapy available for the treatment of an imprisoned lung or the persistence of a pleural space, either infected or non-infected, were the utilization of repeated thoracenteses, various types of drainage procedures or the various types of collapse procedures. Thoracentesis remains a valuable tool and should be utilized early in the course of any pleural effusion to obtain rapid and complete re-expansion of the underlying lung. If this latter purpose cannot be immediately accomplished within a period of a very few days, decortication is the procedure of choice. The remaining two previous methods of therapy, drainage and collapse procedures, are, or should be, largely supplanted at the present time by the procedure of decortication. The principal reason for rejection of the various types of collapse procedures is the fact that the underlying lung following this type of procedure is rendered permanently useless for respiratory function and the patient thereafter carries a deformity which can vary from mild to very marked in the instance of a total collapse procedure of one hemithorax. At the present time drainage and collapse procedures have a very limited indication and usefulness and only in selected individual cases should they be carried out.

Operative Procedure of Decortication

It is not the purpose of this paper to describe in detail the operative technique, however, it is pertinent to enumerate certain aspects of the total surgical care of these patients which are important in fulfilling the accomplishment of the purpose of decortication. First, it is important to time the procedure to obtain as complete restoration of normal pulmonary function as is possible. It has been found that the procedure should be carried out between the third and the sixth weeks following the onset of the disease process. Prior to the third week the peel has not organized sufficiently to be removed readily from the two pleural surfaces. Sometime between the sixth and eighth weeks the peel begins to become firmly adherent to the pleural surfaces and there is increasing difficulty in its removal. Occasionally the patient's general response to the disease forces earlier surgical intervention than would be desirable from the standpoint of organization of the peel. For example see Case No. 7. Secondly, and probably more important, the lung progressively loses its ability to regain normal respiratory function.

Contrary to the original recommendations of Burford, Parker and Samson it is now felt important to remove the parietal as well as the visceral pleural peel. This is particularly important in infants and children where the chest wall will continue to grow and if the parietal peel is left in position, this can cause stiffening of the chest wall and lack of equal growth of the two hemithoraces. (See Case No. 10.) In this same regard it is important to remove the peel from the diaphragmatic surface and mobilize it completely to permit maximum return to diaphragmatic excursion.

A further point of importance is the free-

ing of all interlobar fissures to allow normal re-expansion of each individual lobe. It is, of course, desirable if at all possible, to remove the pleural sac without entry into the infected contents thereof. Frequently, however, this is not possible; therefore, it becomes important to irrigate thoroughly the hemithorax following the procedure to eliminate all possible vestiges of infected material prior to insertion of the drainage tubes and closure of the thorax.

Finally, it is important to avoid parenchymal air leaks as far as possible, and to obtain prompt re-expansion of the lung postoperatively by the use of water sealed drainage with adequate suction applied to the water sealed bottles in the immediate postoperative period. This not only accomplishes prompt re-expansion of the lung and closure of the multiple small air leaks on the surface but also, and more importantly, eliminates any residual space which could lead to development or recurrence of the infection within the hemithorax. At the present time complications are few with this procedure and those that do occur, if promptly recognized, can be very satisfactorily handled with minimal prolongation of the hospital stay postoperatively beyond the usual seven days.

Summary

Pulmonary decortication has been discussed as to its history of development and the purpose of the procedure. The indications for pulmonary decortication in non-tuberculous disease have been broadly outlined and in this regard it is important to keep in mind the fact that in any pleural effusion, whether due to serous, purulent or hemorrhagic fluid, there is a very rapid deposition of fibrinous exudate on the pleural surfaces which quickly becomes invaded by fibroblasts from the parietal and visceral pleurae causing the formation of a fibrous peel over the surfaces of the lung and the chest wall. If early and repeated thoracenteses have failed to prevent the formation of this fibrinous and subsequent fibrous pleural peel, the restoration of a fully expanded and normally functioning lung is impossible without resort to pulmonary decortication. Several case reports have been included in this paper to illustrate various common indications for decortication and to exemplify the fact that the most nearly normal pulmonary function that the patient is capable of obtaining can be brought about by pulmonary decortication, regardless of the length of time the lung has been imprisoned. In this respect it is important to bear in mind the fact that with prolonged collapse of the pulmonary parenchyma, respiratory function is permanently impaired to the point where it may become completely absent in the affected lung. In addition, if the lung is functionless and is allowed to remain so, permanent changes in the bronchial system with the supervention of bronchiectatic changes and chronic infection will occur. The desirability of pulmonary decortication as the treatment of choice in the obliteration of an abnormal pleural space, due to whatever cause, immediately becomes apparent when it is realized that with drainage procedures, the maximum result which may be obtained is elimination of an infected space with the restoration of pulmonary function entirely dependent upon the body's ability to resorb the fibrinous or fibrous peel which is imprisoning the lung. With collapse procedures, an infected space may be obliterated at the sacrifice of pulmonary function and the acceptance of variable degrees of deformity of the chest. With decortication, the maximum obtainable pulmonary function is restored as well as the elimination of the infection and the prevention of deformity rapidly accomplished. The patient is restored to fully normal activity in a very brief period of time in comparison with other methods of management. The incidence of complications is within acceptable limits and those that do occur are readily managed if promptly recognized.

Conclusion

Pulmonary decortication is an effective, safe and rapid means of restoring the maximal obtainable pulmonary function and eliminating persistent abnormal pleural space and potential or actual infection of this space regardless of the underlying cause of the disease process.

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Evaluation of a Systemic Drug, a Nitro-Imidazole ("Flagyl")* in the Treatment of Trichomoniasis

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A new drug from France for treatment of Trichomonas Vaginalis vaginitis is first reported in this country. Seventy patients were treated orally alone; of 55 women, 51 remained negative during observation.

THE protozoan, *Trichomonas vaginalis,* was described by the Frenchman, Donné, in 1836. Although, at intervals, associated organisms have been thought to be the cause of the commonly associated vaginitis, there is little doubt that this flagellate is the etiologic agent in the most frequent type of vaginitis. Its treatment has been a most troublesome problem in clinical gynecology. In the male, the trichomonad infrequently causes clinical urethritis and prostatitis. The organism has been found in 10 to 60 per cent of men whose wives have *Trichomonas vaginalis* vaginitis. That this organism may be passed on by sexual intercourse seems entirely likely, although this method of spread has not been proved conclusively as the only one. It seems possible that the disease may be spread on occasion by bath water, towels, toilet seats, etc., as when the infection is found in mother and daughter, in sisters, and occasionally in young children.

Since the female is the more symptomatically affected, often to the degree of severe vaginitis and even vulvitis, and since symptoms are less frequent in men and the organism more difficult to find, treatment for many years has been directed to the female. In fact, there has been no specific therapy for the male. In our clinic over the past four years we have used numerous drugs in an attempt at cure of vaginitis by local therapy. These have included many of the hundred or so products available, and also many new and untried preparations. The results have never been entirely satisfactory and relapse or re-infection has been extremely common. Local therapy in the vagina cannot be expected to reach all of the areas harboring the organism, such as the cervix, Bartholin glands, Skene's ducts and urethra.

In this paper our observations on the use of a relatively new imidazole, known as Flagyl, indicates that this oral medication has an extraordinary rate of cure of *Trichomonas vaginalis* vaginitis. In fact, it may well be the answer to this very common and perplexing problem. No previous report has appeared in the literature of this country. It has long been held that the final solution to the problem of trichomoniasis lay in the use of a systemic preparation that could be administered to both male and female.

Historical Background

Nakamura,[1] of Japan, discovered 2-nitroimidazole in 1955; its trichomonacidal properties were studied by Horie[2] in 1956, also of Japan. In 1957, 2-acetylamino-5-nitrothiazole (Tritheon) was recommended highly as an oral trichomonacide by Perl, Guttmacher and Raggazoni,[3] but subsequent use indicated disap-

* *The Flagyl used in this study was obtained from G. D. Searle and Co., through the cooperation of J. William Crosson, M.D., Assistant Medical Director.*

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pointingly low cure rates and this medication has been largely discarded. The latter is not an imidazole compound.

Cosar and Julou,[4] in 1959, reported the experimental effects of 1-beta-hydroxyethyl-2-methyl-5-nitro-imidazole, subsequently marketed in France as Flagyl, on *Trichomonas vaginalis,* and found it quite trichomonacidal *in vitro* and *in vivo* in mice, and less toxic in mice, rats and dogs than previous imidazoles. Durel, Roiron, Siboulet and Borel,[5] of Paris, in January, 1959, made cautious claims for Cosar and Julou's "Flagyl", indicating low toxicity, activity *in vitro* and *in vivo,* trichomonacidal power imparted to the semen and urine, and disappearance of the parasite from all male cases and the majority of female cases. In 1960,[6] they reported the cure of 13 men with trichomonas urethritis treated by the oral route. Of six women with *Trichomonas vaginalis* vaginitis treated orally, 5 were cured. Of 21 cases treated orally and locally in the vagina, 17 were cured and four failed of cure. Of four cases treated locally only, 3 were cured. Ten patients had normal blood studies before and after treatment.

Sylvestre and Gallai (1960),[7] of Montreal, reported the treatment of 46 women with *Trichomonas vaginalis* vaginitis and 20 men with trichomonas urethritis and prostatitis. In each instance there was cure. The females were treated both orally and locally in the vagina, the males only orally. They considered that Flagyl is specific for trichomoniasis in the male and female.

Bouziane and Desranleau (1960),[8] of Montreal, reported cure of 41 women and 3 men with Flagyl, with no failures. Both oral (500 mgm daily) and local (500 mgm) administrations were used in the females.

Rodin, King, Nicol and Barrow[9], of London, (1960) reported the treatment of 82 women with *Trichomonas vaginalis* vaginitis with 95 per cent cure immediately, and 83 per cent cure after three months. These patients were given 200 mgm. by mouth three times daily for seven days. Three had *Candida albicans* before and after treatment, and 4 had *Candida albicans* first after treatment. Of 38 male partners, 11 showed trichomonas. Of 20 men treated, no trichomonas could be found in any for 3 months. Ten females had mild gastro-intestinal symptoms, and one had a rash. Of 41 cases with serial blood counts, three had leucopenia temporarily.

Nicol, Barrow and Redmon[10] from London (1960) reported 127 female patients and 11 male patients treated with Flagyl in doses of 200 mgm three times daily orally for five days. Only one had an untoward symptom (vomiting). There were 105 apparent cures. In 17 women there was recurrence. Eleven male patients were given the same dose, with no failures.

Durel, Couture, Collart and Girot[11] (1960), from Paris, indicated that oral administration of Flagyl was as effective as local application to the vagina. After local application, twelve developed yeasts. After oral administration six developed yeasts in the vagina. In 30 cases, no alteration was found in blood examinations.

Willcox[12] (1960), of London, reported 38 cures of 40 women treated orally with Flagyl. Fortier[13] treated 21 women with Flagyl orally and all were cured. Of seven treated *per vaginum,* four were cured.

From the literature available to us from France, England and Canada, we have listed 835 cases of *Trichomonas vaginalis* vaginitis treated with "Flagyl", including those mentioned in discussion of papers. Of these, 725 were said to have been cured (81 per cent). Fifty-seven males with trichomonas infections were listed as having been treated, and all were said to be cured. Minor toxic effects such as gastro-intestinal symptoms and skin rashes were reported in a small percentage. One hundred and three cases were quoted as having had blood studies before and after treatment. Of these, five were said to have developed a leucopenia which had disappeared in each instance when the next blood count was taken. Possible toxic effects must be kept in mind with this nitro-imidazole compound, although at this time the deleterious effects appear minimal.

Case Study

Since November 1960, 55 female patients with *Trichomonas vaginalis* vaginitis and 15 of their husbands have been treated with Flagyl, one gram daily, orally, in two divided doses, for 10 days. Of the 55 women, 51 were cured. Three patients were from our special vaginitis clinic at the Louisville General Hospital. While all three were negative for *Tricho-*

monas vaginalis after two weeks, two had become positive after four weeks. A mild vaginitis had remained present in two of these. No effort was made to prevent re-infection. Eighteen patients were young girls from 12 to 17 years of age and residents of a correctional institution for delinquents. All showed clinical vaginitis. Two weeks after treatment 16 of these patients showed no trichomonas on fresh smear or in culture, but in the remaining two the organism was cultured. These two patients were 13 and 15 years of age. Mild degrees of vaginitis were present in 7 post-treatment. Thirty-four patients were from private practise. All had marked *Trichomonas vaginalis* vaginitis, and several had recurrence after repeated and prolonged local treatment. In all 34, after treatment, the *Trichomonas vaginalis* could not be found in the fresh preparation, or in the 23 who had cultures. These examinations were repeated at intervals up to five months. Eighteen were examined after two months of treatment and two as long as five months. In no instance, in 64 individual, complete, microbiological studies, was the trichomonas recovered in this group.

The *Candida albicans* was found in 3 of the 44 patients cultured before treatment. The same fungus was cultured in 7 patients after treatment. Two additional cases had mycelia in the fresh preparations after treatment. Three were institutionalized girls and six were private patients. Three of these 9 had had the *Candida* before treatment with Flagyl. Possibly the medication allowed the increase of the incidence of *Candida albicans* in a small percentage.

The Döderlein's bacillus was cultured before treatment in 27 of 44 patients (61.4%). After treatment the same patients showed Döderlein's bacillus in 35 or 79.4%. This indicates that Flagyl tends to allow the restoration of the normal flora of the vagina and evidently does not interfere with or decrease it.

The *Trichomonas vaginalis* disappeared immediately in 51 of 55 cases (with fresh preparation, and in cultures in simple trypticase serum medium), the clinical symptoms improved dramatically, but almost half of the patients have had mild or moderate reddening of the vagina to persist for some weeks. Pus cells generally have been minimal in number after treatment, often none being present, even though the vagina continued hyperemic. Examination two or three weeks from the onset of treatment revealed that 14 had normal vaginas on the first observation. One or two plus vaginitis was present in 23 patients at the end of two weeks. After three and four weeks, 14 had slightly reddened vaginas. Seven patients with hyperemia of the vagina were followed to complete reversion to normal after six to sixteen weeks. Of 20 patients followed from 6 to 20 weeks, 16 had normal vaginas and four continued to show mild hyperemia of the vaginas. Four weeks from the onset of therapy five patients had pus cells in the vaginal washings (later study of two showed none). It appears that the hyperemia of the vagina disappears immediately in most cases after treatment with Flagyl, but that half of the cases have a more gradual decrease in the clinical vaginitis. Similarly the pus cells decreased immediately in many, but more slowly in others.

Table I

Trichomonas Vaginalis Vaginitis

	No.	T.V. neg.	Cultured	Candida before Rx	Candida after Rx	Doderlein before Rx	Doderlein after Rx
Patients	55	51	44	3	7	27 (61.4%)	35 (79.4%)
Private	34	34	23	2	4	14	16
Instit.	18	16	18	0	3	13	16
Clinic	3	1	3	1	0	0	3

Husbands treated	15
Semen culture	12
Positive T.V. culture	1 (negative after treatment)

The pH of the vagina before treatment was 4.0 to 4.5 in 9 cases with moderate or marked *Trichomonas vaginalis* vaginitis. Eleven had pH of 5.0, 16 had 5.5, 6 had 6.0, three had 6.5, and four had 7.0. After treatment 19 had 4.0, while 18 had 4.5, seven had 5.0, three had 5.5, three had 6.0, and one had 6.5 (Table

II). This indicates that in general the pH shifted downward after treatment with Flagyl. It is to be noted that the pH of 9 cases was normal (4.0 to 4.5) before treatment. Also after treatment the pH remained the same in 3 cases, and rose in 6 cases. Thus the pH alone is not a criterion of vaginitis or of cure.

Table II

pH in Trichomonas Vaginalis Vaginitis

before treatment							
pH	4.0	4.5	5.0	5.5	6.0	6.5	7.0
cases	3	6	11	16	6	3	4
after treatment							
cases	19	18	7	3	3	1	0

Fifteen husbands of the private patients with marked *Trichomonas vaginalis* vaginitis were treated with the same doses of Flagyl orally (1 gram daily for 10 days). In 12, a semen culture was obtained before treatment. Only one had *Trichomonas vaginalis,* and in this single instance the culture was negative two weeks after treatment began. One case represents a small percentage. Other investigators have reported higher percentages of infection in husbands whose wives have *Trichomonas vaginalis* vaginitis. Re-infection from the husband has been considered an important factor in recurrence of vaginitis. A comparison of the recurrence rates in our patients in the future may throw some light on this, as only a certain percentage of the men have been treated. This series is too small to be of significance, but it is being enlarged. If the untreated husbands re-infect their cured wives, then transference from husband to wife may be considered proved.

Toxic Effects

Of 70 patients, 12 had subjective complaints on questioning, and these were all private patients. Four had slight nausea, one vomited, one had indigestion, one had slight diarrhea, two had bitter taste, and one had temporary rash of the face. One husband became nervous, and a second became nauseated and took only half the medication. All but the latter case completed the medication. It appeared these complaints were mild, and elicited only after questioning. Blood studies were not made in our cases; the possibility remains that leucopenia may be important when large numbers of patients have been treated. All of these 70 patients appeared well and healthy at the termination of their treatment.

Discussion

The introduction of this drug, Flagyl, in France, its adoption in England, Canada, and Germany, and undoubtedly its acceptance soon in this country, as an oral therapy for *Trichomonas vaginalis* vaginitis appears to offer a cure of a distressing and annoying inflammation which occurs in 10 to 80 per cent of adult women (depending on their social and physiologic status). It appears to be the most important contribution yet in the treatment of vaginitis, and specific for *Trichomonas vaginalis. Candida albicans* seems not to be deterred; in fact, its growth may be augmented to some extent. Döderlein's bacillus increases after therapy, and the majority of cases have decreased pH to 4.0-4.5 which is considered desirable and normal. Extensive studies may well reveal resistant cases, which should be studied carefully.

Possible toxic effects appear to be mild and transitory. Temporary leucopenia has been described in a few cases in the literature. This must be kept in mind in general use.

The cure of 51 of 55 women during our observation suggests that Flagyl is most effective. Because the husband may harbor the organism and cause re-infection, in this study fifteen received the same medication simultaneously.

Possibly this dosage of Flagyl may be reduced. Further study of this is necessary. Vaginal applications have not been used in this series. Previous reports and our work suggest that local treatment may be dispensed with.

Summary and Conclusions

1. Fifty-five women with *Trichomonas vaginalis* vaginitis and fifteen husbands of these patients were treated with a new nitro-imidazole, known as Flagyl, in dosages of 0.5 gm. orally twice daily for 10 days. No vaginal therapy was given.
2. Fifty-one of the women (93 per cent) were cured during the periods of observation, which extended from two to twenty weeks. Two failures were in delinquent girls 13 and 15 years

of age. Two other failures were from the clinic. At two weeks their cultures were negative, and at four weeks they were positive. Their husbands were not treated.

3. Of the fifteen husbands treated, 12 had semen cultures before the medication. Only one had a positive culture for *Trichomonas vaginalis,* which became negative after treatment.

4. *Candida albicans* was cultured in 3 patients before treatment and in 7 after treatment.

5. Doderlein's bacillus was cultured in 61.4 per cent before treatment and in 79.4 per cent after treatment.

6. Nine had vaginal pH of 4.0 to 4.5 before treatment, while thirty-seven had this pH after treatment.

7. There were insignificant side effects in 12 patients. Blood studies were not made in this group.

8. Flagyl appears to be specific for the *Trichomonas vaginalis* when given orally.

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Allergic Manifestations In Non-Tuberculous Chest Diseases

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Determination of whether or not a non-tuberculous chest disease is extrinsic rather than intrinsic is based on recognized and relatively simple procedures.

In the differential diagnosis of non-tuberculous chest diseases, allergy should be considered more frequently. Particularly in obscure cases of pneumonitis in which no generalized systemic disease is found, the possibility of an allergic etiology should be kept in mind. Even in well recognized cases of emphysema, chronic bronchitis, and cardiac disease accompanied by pulmonary failure, an underlying allergic cause occasionally is encountered. The vast majority of these latter patients however have a purely intrinsic disease not related to the union of allergen and reagin nor to a stress response of a pituitary-adrenal reaction, conditions with which allergy is supposedly concerned.

Salvage and Rehabilitation of Pulmonary Cripples

The allergist sees many patients who have no allergic disease. Frequently his office or clinic becomes the most convenient area, or dumping ground, from which these chronic non-tuberculous patients can receive repeated prescriptions of broncho-dilator, mucous thinning, or sedative drugs. Perhaps 95% of these patients have a purely intrinsic disease but the remaining 5% may show reversible allergic factors, treatment of which may favorably influence the course of their disease. An even greater salvage rate might be expected should this treatment be instituted before irreversible pathology has developed. It should not remain the province of the allergist alone to determine whether or not these patients are suffering from extrinsic disease.

A Simple Differentiation of Extrinsic Pulmonary Disease

Allergy too often is regarded as a complicated subject involving unusual techniques and exhaustive skin tests. As a matter of fact any good clinician and certainly every physician with a primary interest in chest diseases can make a satisfactory differential diagnosis of extrinsic lung disease in the vast majority of these patients by clinical examination supplemented by a very few skin tests. Dr. Milton Cole,[1] an area V.A. consultant, states unequivocally that not less than 95% of patients with extrinsic asthma can be detected by intracutaneous skin tests to less than a dozen substances and in most cases with only two to four. He states, "A patient who fails to react to an intradermal test with an active-non-irritating house dust extract will not react to any other allergen of clinical importance except to various pollens. Those who react to house dust belong to the extrinsic group; the others may be intrinsic asthmatics with or without complicating chronic pulmonary emphysema, pulmonary fibrosis, and cor pulmonale, or may belong to the primary emphysema group. This statement which has a factor of error of not more than 5%, should be the guide to hospital practice." He suggests that intracutaneous tests be made

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with a 1-40,000 Endo dust, Timothy 0.01 N, and Ragweed 0.01 N strength. Stored in an ice box these extracts remain potent for six months. As an additional factor of safety I would suggest scratch tests be made with concentrated extracts of these same substances and intracutaneous tests be done only when the scratch test is either negative or doubtfully positive.

The majority of medical students and a considerable number of residents and practicing physicians have never observed routine allergy skin testing. The desirability of exposing the medical student to this experience is not generally recognized.

Allergic Pneumonitis

Rubin[2] attributes to chest roentgenography the discovery of significant numbers of patients with pulmonary manifestations of allergic diseases, exclusive of emphysematous states due to bronchial asthma. These conditions may be symptomless and transient or chronic, or they may be progressively fatal. They are usually characterized by pulmonary infiltrations and eosinophilia and are most frequently found in patients suffering from other allergic complaints. The condition is considered fairly common by some writers but not by others.[3] Ashley[3] states that, "Allergic pneumonitis is a commonly encountered disorder that is usually ignored, seldom diagnosed, and rarely treated." McCombs,[4] of the Pratt Diagnostic Clinic in Boston, in contrast, was able to report only eleven cases, nine of which were established by pathological examination.

This group of non-infectious pneumonitis includes: Loefflers syndrome, and an analogous condition, tropical pulmonary eosinophilia; rheumatic pneumonia, associated with acute rheumatic fever; diffuse interstitial fibrosis of the lungs; and Hammon-Rich syndrome, noted since the introduction of the sulfonamides, penicillin, and other antibiotics. Also included are periarteritis nodosa, systemic lupus erythematosis, allergic vasculitis, and granulomatosis, sarcoidosis, beryllium and hexamethonium pneumonitis. When pulmonary complications develop during the course of a so called collagen disease, the diagnosis of allergic pneumonitis should be suspected. An increased eosinophilia often is a valuable clue. It is less apt to be considered intractable pulmonary diseases which lack clinical and laboratory evidence of an identifiable character.

Since adequate steroid therapy may ameliorate the disease and in some instances actually save lives, the importance of determining the allergic origin is self evident.

While lung biopsy should be done with caution in the presence of inflammatory disease, sometimes this is necessary to differentiate the bacterial, virus, or fungus condition, or the tissue pathology.

Russokoff[3] feels that individuals with the clinical diagnosis of allergic pneumonitis, even though they have had lung or supraclavicular lymph node biopsy, should not be treated with corticosteroids without concomitant treatment with antituberculosis therapy, or at least isoniazid. He notes that some patients with a diagnosis of allergic pneumonitis have shown varying degrees of improvement on corticosteroids, only later to die and at autopsy reveal hematogenous tuberculosis.

Conclusion

In conclusion, it is my opinion that all non-tuberculous chest diseases, particularly bronchial asthma, should be classified as to type. The determination whether or not the disease is extrinstic rather than intrinsic is based on recognized and relatively simple procedures. The inclusion of such measures is suggested in the differential diagnosis of obscure or undiagnosed pulmonary conditions.

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CASE DISCUSSIONS
From The
University of Louisville Hospitals

Louisville General Hospital

Delirium Tremens

Robert Clary, M.D.*

Case Report

THIS patient, a 45-year-old, white, divorced male, was first seen in the early evening in the Emergency Room of the Louisville General Hospital, complaining of pain in the left wrist. He was reported as appearing quite intoxicated but in good contact. There was no obvious difficulty with the wrist, but it was x-rayed, nonetheless. This procedure consumed about 20 minutes and when he was returned to the Emergency Room his entire demeanor had changed, and he was reported as "seeing things." The Psychiatric Resident was called and when the patient was seen he was cowering in the corner of an examining room, appeared completely terrified, and was screaming, "There they come! Don't you see them? Oh, God, don't let them get me." He said he saw bugs, large rats, and small men with pasty, bloated faces advancing toward him. He was completely disoriented at this time and, except for very occasional lucid moments when he said that "Something is happening to my mind. What is happening to me? Oh, God, help me!" he remained terrified and inaccessible. He was immediately admitted to the Psychiatric service and therapy was started. This consisted of 12 cc. of C. P. paraldehyde by mouth and an intravenous injection consisting of 2000 cc. of 5% glucose with 20 units of regular insulin, 200 milligrams thiamine chloride, 100 milligrams nicotinic acid, and 2 ampules of Beroca C. More paraldehyde was required eight hours later, and at this time he received 8 cc. By morning, some 12 hours after admission, patient was m a r k e d l y improved, was in good verbal contact, but still not too positive as to time and place. He was able to eat a soft diet and was cooperative in forcing fluids by mouth as well as taking oral vitamins, consisting of thiamine chloride 100 milligrams, nicotinic acid 50 milligrams, and one commercial multivitamin tablet.

Physical examination showed a moderately obese, white male, with gross fine tremor of the upper extremities, a non-tender liver palpable one and one-half centimeters below the right subcostal margin. Blood pressure was 160/88; temperature 99; pulse 100; respiration 18. There were three vertical, lower abdominal, healed surgical scars approximately 10 centimeters in length.

The patient was encouraged to remain out of bed, was helped to sleep his second night with 8 cc. paraldehyde, and the light was kept on in his room to help his orientation. From the second hospital day he was very pleasant and cooperative, but the fluids and vitamins were continued in the face of his residual tremulousness. No sedation was given on the third night and he slept well, and on the third hospital day he became completely asymptomatic.

Past history shows a long record of alcoholism. He had actually been a field grade officer in the military, but was finally discharged for excessive drinking and striking a fellow officer. At this time he was working as a barber. He stated he had been drinking in his usual spree pattern for nearly three weeks, had been eating only sporadically during most

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of that time, and, as well as he could recall, had eaten nothing for some three or four days before coming to the hospital. His general condition continued to improve and his sensorium remained intact, therefore he was discharged after four and a half hospital days.

Discussion

Frank M. Gaines, M.D., Associate Professor of Psychiatry: Diagnosis of delirium tremens is based on: 1. History of acute or chronic alcoholism. This may occur following a large alcoholic intake over a period of a few days or, more commonly, a small or moderate amount of alcohol over a long period of time, perhaps months or years. In the latter case, delirium tremens may be precipitated by change in eating habits, as was apparently the case with this patient; by some intercurrent infection; or by some type of trauma. 2. Gross tremor. 3. Visual and/or auditory hallucinations. The traditional "pink elephant" is a rare manifestation. Instead, hallucinations are characterized by fear which approaches panic. Because of this the patient should be protected from any suicidal possibilities or impulsive and dangerous acts as an attempt to escape from the frightening hallucination. 4. There may be alternating periods of lucidity and confusion. 5. Differential diagnostic problems are: toxic delirium due to drugs (such as bromides, barbiturates); head injury; acute schizophrenic states and cerebral fat embolism (in the presence of associated trauma).

John P. Bell, M.D., Associate Professor of Psychiatry: This case calls to mind a number of the important features of this illness: its sudden onset, the danger of suicidal or homicidal attacks as a result of the gross disorientation and fearful hallucinations, and the possible critical, even fatal complications of any acute excitement.

My own routine for the handling of these acute brain syndromes would emphasize the fluids, vitamins and paraldehyde as used in this case. In addition, I almost routinely use chlorpromazine and Dilantin. The chlorpromazine is given in doses of from 50 to several hundred milligrams every 3 to 4 hours when awake and I see practically no adverse reactions. It may be started intramuscularly with 25 to 50 milligrams if oral administration is impossible. The Dilantin is used to prevent the seizures which are frequent complications and is given in doses of 0.2 to 0.4 grams stat and 0.1 grams 4 times a day for 7 to 10 days. Some physicians feel that with the immediate and liberal use of chlorpromazine, paraldehyde is less necessary. Personally, I find it very helpful and encourage the nurses to use it freely during the first 72 hours to control the tremulousness, etc. Cortizone and ACTH have been reported of value by some investigators, but I have had little personal experience or need for these drugs. The importance of good nursing care to maintain nutrition, hydration, and to be forewarned of possibly complicating factors cannot be overestimated.

The above routine is applicable, not only for the treatment of delirium tremens, but for its prevention in patients who come into the hospital with a history of acute or chronic alcoholism. Barbiturates and meprobamates are avoided with all of these patients. Scopolamine is occasionally helpful in the unusual case whose acute excitement fails to respond to chlorpromazine and paraldehyde in adequate quantities.

The severity of symptoms in these cases frequently creates a great problem in the general hospital setting because of their special nursing needs and the disturbance they create to other patients. It is difficult to protect patients and personnel from physical harm and to give adequate nursing care without resorting to mechanical controls or over-sedating chemically. The special facilities of a psychiatric section or hospital are of great advantage here.

Hollis Johnson, M.D., Associate Professor of Psychiatry: The case presented by Dr. Clary is a rather typical case of acute brain syndrome due to alcohol or delirium tremens. I would like to discuss the problem of alcoholism in general, particularly with regard to the development of a delirium. The patient described falls into the average age range where we see the first delirium. It is exceedingly rare for us to see a case of delirium tremens develop without a history of at least ten years of excessive drinking. Although over the years it has been felt that the delirium was due to the toxic effect of alcohol itself, recent work has demonstrated that the delirium that occurs with alcohol withdrawal is not materially different than that that occurs with barbiturate withdrawal. Alcohol is a rapidly metabolized sedative. When it is ad-

ministered over a long period of time, some type of physiological dependence of the brain develops on this sedative. Since it is so rapidly metabolized, it becomes impossible for the patient to keep up with the increasing needs of sedation in order to prevent tremors, convulsion and/or delirium.

It is this concept that offers a rationale for the substitution of longer acting and more potent sedatives such as paraldehyde which was used in this case. Paraldehyde is probably one of the best sedatives for use in this purpose. Since the introduction of the chlorpromazine derivative drugs, many people treat acute brain syndromes of this type with Thorazine or Sparine alone. For the most part, in my experience, I still find these patients easier to manage if supplemental doses of paraldehyde, usually USP, or some other effective sedative such as Nembutal is administered.

One must keep in mind the basic dependency that these people have developed on the drug alcohol. The same risk exists with tranquilizers and other sedatives. For this reason, in addition to administering Dilantin, 300 to 400 milligrams daily, with the hope of preventing convulsive seizures, we try to keep these patients in the hospital for a sufficient period of time so that they become reasonably comfortable without medication.

The pattern of depending on a sedative effect of alcohol and/or other sedatives has become well-established by the time a delirium develops. If the patient is experiencing an extreme amount of tension, tremor, insomnia at the time of discharge from the hospital, even though his delirious symptoms have cleared, the risk of immediate resumption of the use of alcohol is greater.

Chronic alcoholism is among the most difficult of psychiatric problems. These patients need every resource if they are to become effective at remaining abstinent. This has been well established as being the only solution for the alcoholic. Although we try to interest patients in the psychiatric approach to their difficulty, those who become interested in psychotherapy are the exception and not the rule.

Comparison of Surgical Treatments of Duodenal Ulcer

Results of these two operations, 50% gastrectomy with vagotomy and 75% gastric resection, in the treatment of duodenal ulcer show that the operative mortality in each case is 1%. Postoperative complications are slightly higher after 50% gastrectomy and vagotomy, but this operation accomplishes the physiological aim of an operation for duodenal ulcer more completely by obtaining an eduring and adequate reduction of gastric acid. There were no recurrent ulcers following 50% gastrectomy and vagotomy in follow-ups averaging 3.6 years; there were 3 recurrent ulcers in the 75% gastric resection in follow-ups averaging 5.2 years. Follow-up studies indicate an excellent result in 92% of cases after 50% gastrectomy and vagotomy; after 75% gastric resection they were excellent in 79%, good in 17%, and fair or poor in 4%. Comparison of the postoperative weight and dumping syndrome was definitely in favor of the 50% gastrectomy and vagotomy. It is concluded that the 50% gastrectomy and vagotomy is the better operation for patients with duodenal ulcer than the 75% gastric resection.—*L. K. Ferguson, J. L. Bravo, and M. Nusbaum, Archives of Surgery—Vol. 82:627 (April) 1961*

SPECIAL ARTICLES

Elevate Yourself

Edward B. Mersch, M.D.*

A long time ago a noted specialist said that his secret of success as a physician was keeping the patient's head cool and his feet warm. And it is just now becoming generally known that a "hot head" and "cold feet" are enough to bring disaster to even a well man. And so it is with medicine today, so also with industry and labor.

Discontent seems to be the byword; and there are two kinds of discontent in this world: the discontent that works, and the discontent that wrings it's hands. The first gets what it wants, and the second loses what it has. There is no cure for the first but success; and there is no cure at all for the second.

Economics is fancy for the political picnic that two kinds of people attend—those who bring their lunch, and those who live for the handout. So it is with so-called medical economics.

The only worthwhile things that come to man in this life come through work. And work is usually hard and often bitter. This has always been true of mankind and will always remain so. The "have nots" would like to tear down the "haves" to their level, rather than try to build themselves up to the "haves."

You men and women are about to graduate from Medical School. You will receive your Doctor of Medicine degree, receive a diploma to hang, or not to hang on your wall, and will receive the felicitations of your friends and perhaps the plaudits of a few. But don't let a feeling of self-satisfaction overcome you. This is only the beginning. Doctor Martin Fischer said "you don't start being a doctor until the medical school and the hospital have kicked you out upon the street." You become a doctor —a physician—when you understand your sick patients and administer honestly to them.

A doctor must be more than a parrot of things medical he has acquired while in training. He must use his mind and body, his soul and heart in administering to the sick. A doctor who fails to use understanding and kindness, compassion and firmness, honesty and justice along with his medical knowledge, is usually more sick than his sick patient. Develop more than mere book-knowledge. You cannot gauge your success by the number of patients you have, nor by your income from them. You should measure yourself by how well you have treated them; how honestly you tried to diagnose and care for them; how faithfully you tried to understand their difficulties; have you treated them like you yourself would like to be treated.

Learn how to make a place for yourself through merit, and not through push. The right road to distinction is that of merit, and when industry is joined to worth it is a short cut to the stars, even though it seemed long at the time. Mere goodness is not enough and push is unbecoming, for then things arrive so soiled that they produce loathing, and your best efforts may become despised. The glory seekers may stand out like a bright light on a dark night, but their sparkle soon becomes a fizzle and nothing but a smoldering stench remains. Be remembered for your good things and not for the bad.

**Address delivered at 1961 Senior Day program, University of Louisville School of Medicine.*

Realize that the perfect does not lie in quantity, but in quality. The best are always scanty and rare. Mass in anything cheapens it. Even among men the giants have often been true pygmies. Some judge books by their thickness, as though they had been written to exercise the arms and backs instead of the mind. Bigness, alone, never gets beyond the mediocre, and it is the curse of universal man that in trying to be everything he is nothing. It is quality that shows distinction. Make your profession one of a higher quality. Its distinction is quality, and its substance, sublime.

Accomplish your ends, sometimes indirectly, and sometimes directly. Realize that life is a struggle of man against man's malice. Don't let service dull your sensibilities and greed your judgements. Recognize that bad form spoils everything, even justice and reason. Good deportment is the gala dress of life, and a happy ending to everything. A cured, happy patient can become unwell again with an unreasonable fee. An unhappy patient who believes he was cheated is a liability, and a good doctor lives on his assets, not on his liabilities.

Make a good exit. You are entering a great profession through the gates of pleasure and fortune. Don't leave it through the gate of sorrow. Keep in mind the final curtain, paying greater heed to the happy exit than to the applauded entrance. Prepare yourself for encores —and these are few—rather than for the boos —which can be many. Fortune follows few as they leave; polite as she is to the arriving, equally discourteous is she to the departing. Make your departing a swcet one—a sweet remembrance is always cherished. A beloved doctor is next to God. But you must earn your loving, and love is two-sided. It is give and take, and the giver reaps the greatest rewards, so that in things final, the giver is the grcater receiver. Hearken to this.

Be just in your judgment. Some men are born wise; with an inborn sense of right and wrong they enter upon a prudent conduct of life, and thus half of their journey to success is over. The years and experience develop their understanding, and so they attain a judgement most tempered: they despise all prejudice as a temptation of the spirit, espccially in matters of money. Don't let your pocketbook prejudice your thinking. A good doctor does not have to seek the dollar—it will seek and find him.

Choose yourself an heroic ideal, more as something to emulate, than as something to imitate. There are many men of greatness in your profession—set before you one of the greatest, not so much as someone to follow, but rather one to spur you on, for that same impulse which buries jealousy lifts up the noble spirit, and there is no nobler spirit than ours—the spirit of giving ourselves to succor the ill.

Cardinal Gibbons said "The higher men climb the longer their working day. And anv young man with a streak of idleness in him may better make up his mind at the beginning that mediocrity will be his lot. Without immense, sustained effort he will not climb high. And even though fortune or chance were to lift him high, he would not stay there. For to keep at the top is harder almost than to get there. There are no office hours for leaders." So be it with physicians. Your work is never done, the hours in the day are too few. Keep busy so that quality sits at the top of the ladder.

It was Confucius who said: "The nobler fort of man emphasizes the good qualities in others, and does not accentuate the bad. Thc inferior does the reverse. Thc nobler sort of man pays special attention to nine points. He is anxious to see clearly, to hcar distinctly, to be kindly in his looks, respectful in his demeanor, conscientious in his speech, earnest in his affairs. When in doubt, he is careful to inquire; when in anger he thinks of the consequences; when offered an opportunity for gain, he thinks only of his duty."

And remember that duty is the complement of right. One is impossible without the other. They are correlatives. Duty, like right, has a term, that is, someone to whom it is owed—to God, to our neighbor and to a lesser degree to ourselves. In a sense then, the sick patient has a right to your serviccs as a physician, and he in turn a duty to you. If he accepts your services, then he is duty bound to pay for them. But let your fees be commensurate with your skills and his ability to pay. You will find greater solace at times in a 'heartfelt thank you,' than in a monetary reward. But everyone should also realize that final reimbursement for services is just as duty bound as payment for definite concrete goods, and the physician has the right to expect payment. Make your fee rcasonable, gain the confidence of your patients, and you will bc paid well.

It was Henry Ford who said: "The object of living is work, experience, happiness. There is joy in work. All that money can do is buy us some one else's work in exchange for our own. There is no happiness except in the realization that we have accomplished something." And you as physicians, can accomplish the most. You certainly will be able to work; you should gain and achieve experience, and happiness will result. I hope it leads to joy for both you and your patients.

Strive to be in demand. There are ways of gaining this prize of adoration; excellence in a post and excellence of the talents assure it. Charm of manner is efficacious, for dependence is built up of such properties, because of which it is soon discovered that the man needed the office less than the office needed the man; the posts bring honor to some men and some men bring honor to the posts. Your profession—medicine—has long been honored. You will be honored by your profession, see to it that you honor the profession.

Don't let your knowledge of science outstrip your knowledge of man. The art of medicine should never be forgotten—it should be nurtured and cultivated. It is the art which helps to heal the 'soul'. It at times goes much farther than all of the science and 'wonder drugs'—don't loose the art. The art of medicine devolops between you and your patient; it does not accept a third party. So-called third party medicine can lead to it's destruction.

Be wary of any third party which interferes, beware of and shun state, federalized, socialized, panelized or whatever name it uses, for government or it's agencies soon forget the man. Personalities are lost. Confidences are shaken. The individual becomes a pawn of the State—he exists for the State, rather than the State for him. And gentlemen, that is the direction in which this country is heading. Take heed to what happened to your brothers in other lands, where the State controls the Practice of Medicine. Ask yourself is this really what you want. And project yourself into the future,—do you want to enslave future generations because it seems expedient now? Too many accept security for freedom, and more and more government leads to State slavery. Ponder this, think upon it, and don't be misled. When freedom from want, and freedom from fear are achieved, man's remains will be in rigor mortis, for it is only death that stills all the qualities and functions of mortal man.

Don't let yourself be narcotized by panaceas and promises of utopia. These are but the words of poets, they are the opiates of the dreamers. They can lull your sensibilities into insensibles. They are nonsensical approaches to reality. Life is work and suffering, it is pleasure and pain, it is living and dying, and man is endowed with life. But life is made up of but three instincts, eating-drinking, sex and work. How much of the mind or rational being enters into the play? Alert your mind and make a better life.

Keep your mind alert in your practice. Remember. diagnosis is not the end, but the beginning of practice. A good history and physical examination leads to 75% of diagnoses —and these in themselves are not expensive. The ancillary services bring up the cost. When you no longer know what headache, heartache or stomachache means, without cistern puncture, electrocardiograms and X-ray plates, you are slipping. And if you proceed to order pages of laboratory work before you have seen the patient, you have slipped.

Be honest with yourself and with your fellow-man. Render honest services and you will receive just and honest rewards. But be ever on the alert, for there are always a few who beget without working. The connivers and 'do-gooders' seek their own advancement on empty and fallacious promises. Plato said: "Democracy does not contain any force which will check the constant tendency to put more and more on the public payroll. The State is like a hive of bees in which the drones display, multiply and starve the workers so the idlers will consume the food and the workers will perish."

Receive ye this advice and profit by it.



Eternal Vigilance

ON OCTOBER 20, 1957, the "Kentuckiana Children's Chiropractic Center" commenced rent-free operations in a portion of the old Nichols General Hospital property in Louisville, and immediately inquired of the Kentucky Department of Health as to whether it qualified to receive government surplus property. The question was referred to the U. S. Department of Health, Education and Welfare, which ruled that, as a hospital or clinic, the Center could not qualify without Kentucky Health Department approval. The record shows that Senator Morton's office expressed interest in the matter through the medium of at least one telephone call to the Department of Health.

Departmental approval was of course withheld when it was established that the clinic was treating children whose conditions were variously diagnosed as asthma, heart, bronchitis, hearing defects, visual defects, post polio, brain injury, rheumatic fever, encephalitis, mental retardation, epilepsy, cerebral palsy, nervousness, Bells palsy, herpes, hydrocephalus, sinusitis, chronic constipation, retarded speech, ptyalism, muscular retardation, spasctic tendons of Achilles, ruptured disc, partial paralysis, muscular dystrophy, eczema, Charcot's knee, progressive palsy, and talipes valgus by the single method of spinal adjustment.

Undaunted, in 1960-61 the director of the Center enlisted the active assistance of Senator Cooper, who pointed with pride to his co-sponsorship of the legislation which created the Kentucky State Board of Chiropractic Examiners, and urged the Department of Health, Education and Welfare to accept the Board's approval of the Center as that of the "appropriate" state agency.

After a series of high-level conferences arranged by Senator Cooper, one of which was attended by Secretary Ribicoff and Under Secretary Nestigen, a new application in which the Center proposed, as an *educational* institution, to continue its present clinic; build a chiropractic hospital; conduct schools for retarded children, chiropractic nurses aides and technicians; and carry on internship programs for chiropractor "interns" and teachers who seek qualification for work with the mentally retarded, was approved, despite the fact that the Board of Chiropractic Examiners is the only *state* agency which has approved the Center or its program!

The Kentucky Department of Health (which was not informed of the Center's application as an "educational" institution) has registered a vigorous protest, but it comes late—perhaps too late. Involved is 11.23 acres of land valued at $56,350, exclusive of 11 buildings located on it, and to which no value is assigned. If the transfer is completed, your government will have contributed that much to the ongoing of chiroquackery in Kentucky.

Two morals can be drawn from this experience: (1) Educate your legislators, state and national, concerning the cult of chiropractic; (2) be eternally vigilant to detect and counter the continuous maneuverings of this group to up-grade its professional standing by political means instead of additional training.

Alfred O. Miller, M.D.

The Enemy Within

DURING the Spanish Civil War, a city fell to the enemy in a surprisingly short period of time. In explaining this victory the commanding general stated that he had four columns without the gates of the city and a fifth column within, with major credit going to the latter.

Today, medicine is engaged in the most serious and critical fight in its long history, for at stake is nothing less than the survival of medicine within the framework of the free enterprise system. Enactment of the King Bill (HR 4222) into law will mark the beginning of the end of our present system of medical practice; and in time every man, woman and child will be included under a system of compulsory federal medicine.

One would think that this threat not only to medicine but to freedom itself would evoke an overwhelming response from physicians throughout the country. What clearer call to arms could we possible have? What greater threat must prevail us to overcome this deadly apathy so widespread among us? For the truth is that most physicians demonstrate a degree of unconcern and disinterest which is frightening. Business as usual and too busy to be bothered are the prevailing attitudes today.

Apathy is our enemy within, and a more deadly enemy scarcely exists. It is one thing to be disinterested in the ordinary day-to-day problems that make up organized medicine. It is quite another to remain apathetic in the face of legislation which, if passed, may destroy free enterprise medical practice.

Is it possible that this apathy, so widespread and harmful, exists because of fallacious concepts in regard to liberty and freedom? Do most of us believe that our part in the never-ending struggle to preserve liberty, justice, self-determination and freedom can be delegated to others? If so, we delude ourselves. While our county and state societies and the American Medical Association can accomplish much in this struggle, in the last analysis, it is the efforts of the individual that count the most.

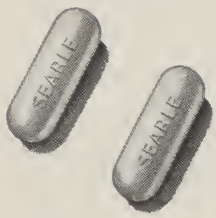
The issues are clear. We as an organization and as individuals have a magnificent opportunity to speak for freedom. We feel sure that to do this through apathy may well mean defeat. Let each of us act now and assure victory.

Robert C. Long, M.D.

The pattern of man's development can be placed in nine periods of growth and deterioration as follows:

From bondage to spiritual faith . . . . .
From spiritual faith to great courage . . .
From great courage to liberty. . . . . .
From liberty to abundance . . . . . .
From abundance to selfishness . . . . . .
From selfishness to complacency . . . . . .
From complacency to apathy . . . . . .
From apathy to dependency . . . . . .
From dependency to bondage . . . . . .

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ORGANIZATION SECTION

Dr. Elliott Releases Information on Annual Meeting Speakers

Information on four of the outstanding speakers scheduled to address the general scientific sessions at the 1961 KSMA Annual Meeting were released at press time by Richard G. Elliott, M.D., Lexington, KSMA president. Complete information on the meeting will appear in the August Annual Meeting section of the Journal.

Guest speakers announced by Doctor Elliott include: Alston Callahan, M.D., Birmingham, guest of the Kentucky Eye, Ear, Nose and Throat Society; Conrad G. Collins, M.D., New Orleans, guest of the Kentucky Obstetrical and Gynecologic Society; William S. Langford, M.D., guest of the Kentucky Chapter, American Academy of Pediatrics; and Louis J. West, M.D., Oklahoma City, guest of the Kentucky Psychiatric Association.

Alston Callahan, M.D., president of the Eye Foundation in Birmingham, is a graduate of Tulane University School of Medicine in 1933 with an M.D. degree. He is a member of the staffs of Carraway Methodist Hospital and University Hospital in Birmingham. His internship and residency training were taken at Charity Hospital, New Orleans. Before going to Birmingham he was in private practice in Vicksburg and Atlanta.

He will address the general session on Wednesday, September 30, at 2:40 p.m. on "Sight Saving Measures" and that morning will participate in a panel discussion at 10:50. His topic before the EENT group on Thursday morning, September 21 at 10:00 will be "Newer Concepts for Plastic Ophthalmic Surgery."

"Obstetrical Emergencies" will be the subject of Conrad Collins, M.D., talk at the first scientific presentation of the meeting following the opening ceremonies at 9:00 on Tuesday, September 19. He will address the Kentucky Ob.-Gyn. group at 2:00 that afternoon on "Urological Problems in Ob. and Gyn."

Doctor Collins, professor and chairman, department of obstetrics and gynecology, Tulane University School of Medicine, is also obstetrician and gynecologist chief, Tulane Unit, Charity Hospital of Louisiana. He is a 1928 graduate of Tulane School of Medicine. A national consultant to the surgeon general, U. S. Air Force, he is a member of the American Gynecological Society, American College of Surgeons, and American College of Obstetricians and Gynecologists.

William S. Langford, M.D., director, Pediatric Psychiatric Clinic, Babies Hospital, Columbia-Presbyterian Medical Center, is also attending pediatrician, Vanderbilt Clinic, professor of psychiatry at Columbia University and attending psychiatrist, New York State Psychiatric Clinic. He graduated from the Columbia University College of Physicians and Surgeons in 1931. He is an associate fellow of the American Academy of Pediatrics and a Fellow of the American Psychiatric Association.

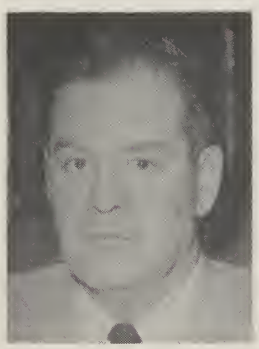
Doctor Langford will give an address entitled, "Hyperkinetic Behavior Disorders in Children" at the general session on Tuesday morning, September 19 at 10:50. Following his talk he will participate in a panel discussion at the general session at 11:10. That afternoon his talk before the Kentucky Chapter, American Academy of Pediatrics will be "Headache in Children."

"Hypnosis in Medical Practice" is the subject to be discussed by Louis J. West, M.D., at the general session on Thursday, September 21 at 2:00 p.m. Before the Kentucky Psychiatric Association at 10 that morning he will deliver a talk called "To Dream or Not to Dream."

Professor and head of the department of psychiatry, neurology and behavioral sciences, University of Oklahoma, School of Medicine, Doctor West graduated from the University of Minnesota Medical School in



Alston Callahan, M.D.



Conrad Collins, M.D.



William S. Langford, M.D.



Louis J. West, M.D.

1949. He took his residency training at the Payne Whitney Clinic, New York Hospital. A Fellow of the American Psychiatric Association, he is research coordinator for the Oklahoma Alcoholism Association and Chief, Behavioral Sciences, Oklahoma Medical Research Foundation.

Journal Editors Appoint Eight New Consultants

Sam A. Overstreet, M.D., editor of The Journal of KSMA, and George W. Pedigo, Jr., M.D., associate editor, both of Louisville, announce the appointment of eight new members to the Board of Consultants on Scientific Articles of The Journal.

Each year eight consultants are replaced on the 24-member board. Members serve a three-year term and cannot succeed themselves. They review scientific articles submitted for publication in The Journal.

New appointees are: William Oldham, M.D., Owensboro, eye, ear, nose, and throat; Orville T. Evans, M.D., Lexington, proctology; Randolph T. Gilliam, M.D., Lexington, urology; Herbert L. Clay, Jr., M.D., Louisville, internal medicine; John Gordinier, M.D., Louisville, OB-GYN Samuel M. Smith, Jr., M.D., Louisville, internal medicine; and Howard W. Ripy, M.D., Lexington, pediatrics. Their terms start July 1.

Retiring members of the board are: Merle W. Fowler, Jr., M.D., Paducah, eye, ear, nose and throat; Wilford L. Cooper, M.D., Lexington, proctology; Robert S. Dyer, M.D., Louisville, internal medicine; Charles Rankin, M.D., Lexington, internal medicine; Oscar Hayes, M.D., Louisville, OB-GYN; Ralph Denham, M.D., Louisville, internal medicine; Robert Warfield, M.D., Lexington, pediatrics; and Nathaniel L. Bosworth, M.D., Louisville, urology.

Appreciation was expressed to the consultants by Doctor Overstreet for their valuable services and constant efforts to improve the Scientific Section of The Journal.

Governor's Safety Conference Attracts 750 Delegates

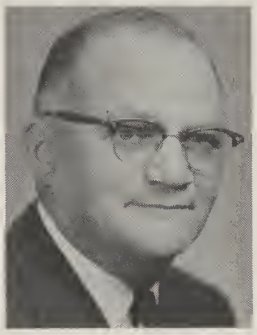
Twenty-four physicians, including KSMA officers and members of the KSMA Committee on Highway Safety, were among the 750 persons representing each of Kentucky's 120 counties at the "Governor's Safety Conference" in Lexington on June 13 and 14. Glenn Lovern, Kentucky's Commissioner of Public Safety, was general chairman.

Fifteen Kentucky groups sponsored the conference which was aimed at informing, inspiring, and encouraging delegates to go home and correct local conditions. Talks by both Governor Bert T. Combs and Lt. Governor Wilson Wyatt were featured at the conference which stressed highway safety.

Arthur H. Keeney, M.D., Louisville, chairman of the KSMA Committee on Highway Safety, complimented Mr. Lovern and his department for an "extremely well planned and well coordinated conference" calling it "a most worthwhile event which should do a great deal toward promoting safety throughout the state."

Petersen to be Featured Speaker at President's Luncheon

"This Too is the Practice of Medicine" is the topic which will be discussed by T. C. Petersen, Chicago, Ill., at the KSMA President's Luncheon on Wednesday, September 20, according to an announcement by Richard G. Elliott, M.D., Lexington, KSMA president.



T. C. Petersen

Doctor Elliott said, "Mr. Petersen is very much in demand as a speaker. He has spoken before various state medical associations, including Ohio and Illinois and has a reputation as an excellent and scintillating speaker."

A native of Iowa, he was named director of the American Farm Bureau's program development division in 1959. Mr. Petersen graduated from Iowa State College in 1932 and started work for the Wisconsin Farm Bureau Federation in 1942. In 1949 he joined the American Farm Bureau Federation staff.

Painting of McDowell Operation Presented to Health Dept.

Presentation of an oil painting by the late Dean Cornwell, Louisville artist, entitled, "The Dawn of American Surgery" was made to Governor Bert Combs representing the Health Department and the Commonwealth by Wyeth Laboratories, Philadelphia, at ceremonies in Frankfort on June 13. Health Commissioner Russell Teague, M.D., presided at the presentation.

Depicting the first successful ovariotomy by Ephraim McDowell, M.D., in 1809 at Danville, the picture will hang in the State Department of Health building. Part of the series entitled, "Pioneers of American Medicine," the 60 x 70 inch painting was on display at the KSMA Centennial meeting in 1951.

Cornwell, a Louisville native and internationally-known muralist and illustrator was commissioned by Wyeth to do six paintings in the series which he called "my finest and most worthwhile work." He started work on the series in 1939 and finished in 1945.

Col. Graham Visits Louisville

Colonel W. D. Graham, MC, USA, new director of the Medicare Program, visited the KSMA offices and Kentucky Blue Shield offices in a visit to Louisville on May 31. Colonel Graham spent some time in both offices and expressed approval for their operations.

His visit to Kentucky was part of a good will tour among the Medicare contractors. The Blue Shield Plan for Kentucky is the fiscal administrator for the Medicare program. Col. Graham replaced Brigadier General Floyd L. Wergeland, MC, USA, as Medicare Director. General Wergeland is now Commanding General of Walter Reed General Hospital.

U of K College of Medicine Announces Appointment of Voluntary Faculty

As a part of its planning and preparation for clinical teaching, the College of Medicine has begun appointing voluntary faculty members to its staff. In a public statement accompanying the announcement of these first appointments, the College said:

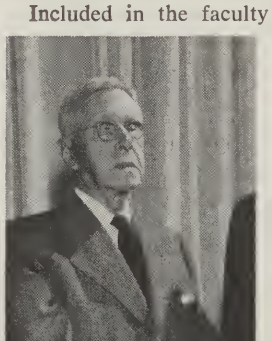
"The University believes that academic and patient care programs of the University of Kentucky Medical Center will be enhanced by the participation of voluntary faculty, and that advantages will accrue to patients, students, the medical profession, the University and the Community." Some pertinent reasons for this are:

1. The voluntary and part-time faculty members often have special competence in certain types of clinical experience such as the subspecialties and the illnesses most commonly dealt with in family practice. Hence, they are prepared to make an important contribution to teaching and patient care.

2. It is difficult even in the most completely staffed medical schools to have sufficient full-time faculty members to engage in all the necessary teaching activities, particularly when the emphasis is on small group teaching and prolonged contact with, and supervision of, the student. Thus, the voluntary and part-time faculty members can provide significant assistance to the total teaching program.

3. Students and full-time faculty will obtain a better perspective of community problems and the role of the medical profession; conversely, the medical profession in this area will understand better the programs and role of the Medical Center in the local community and the State.

Included in the faculty appointments was that of John W. Scott, M.D., formerly chief of the Department of Internal Medicine at St. Joseph Hospital and Chief of the Department of Internal Medicine, Good Samaritan Hospital, Lexington, as Professor of Clinical Medicine. A former KSMA president and director of the Kentucky Heart Association, he received the Distinguished Service Award from the KSMA in 1952.



John W. Scott, M.D.

According to Dr. William R. Willard, Vice President for the Medical Center and Dean of the College of Medicine, "Voluntary faculty members are those who have an official faculty appointment in the College of Medicine for which no stipend or salary is received and who devote only a part of their time to the program of the medical school. Because voluntary faculty members must accept substantial commitments of time to the teaching and research activities of the Medical Center, it is fully understood that many qualified physicians in the greater Lexington area will be unable to participate in this program."

Other appointments to the voluntary faculty to date are:

Daniel C. Beittal, presently Acting Chief, Psychiatric Service No. 2, USPHS Hospital, Lexington, Kentucky, appointed Instructor of Clinical Psychiatry.

John Berry, Jr., presently on the medical staff at Good Samaritan Hospital, Lexington, Kentucky, appointed Instructor of Clinical Radiology.

H. Davis Chipps, presently Pathologist, Central Baptist Hospital, Lexington, Kentucky, appointed Professor of Clinical Pathology.

Colby N. Cowherd, presently on the medical staff, Lexington Medical Center, Lexington, Kentucky, appointed Instructor of Clinical Radiology.

John A. O'Donnell, presently Chief, Social Service Section, USPHS Hospital, Lexington, Kentucky, appointed Adjunct Assistant Professor of Behavioral Science.

Raymond Forer, presently with the Division of Behavioral Science, Kentucky State Health Department, Frankfort, Kentucky, appointed Adjunct Assistant Professor of Behavioral Science.

Zygmunt Gierlach, presently on the medical staff, Lexington Medical Center, Lexington, Kentucky, appointed Assistant Professor of Clinical Radiology.

Sherman N. Kieffer, presently Chief, Psychiatric Service No. 1, USPHS Hospital, Lexington, Kentucky, appointed Assistant Professor of Clinical Psychiatry.

Charles C. Laurent, presently Assistant Chief, Psychiatric Service, No. 1, USPHS Hospital, Lexington, Kentucky, appointed Instructor of Clinical Psychiatry.

David H. Looff, presently Assistant Chief, Psychiatric Service No. 2, USPHS Hospital, Lexington, Kentucky, appointed Instructor of Clinical Psychiatry.

James Maddox, presently Deputy Medical Chief, USPHS Hospital, Lexington, Kentucky, appointed Assistant Professor of Clinical Psychiatry.

James McClellan, presently Associate Professor of Clinical Pathology, Department of Microbiology, University of Kentucky, Lexington, Kentucky, appointed Associate Professor of Clinical Pathology.

Kenneth McGinnis, presently on the medical staff, Lexington Clinic, Lexington, Kentucky, appointed Instructor of Clinical Radiology.

Robert A. Stewart, presently Director of Laboratories, King's Daughters Hospital and Our Lady of Bellefonte Hospital, Ashland, Kentucky, appointed Assistant Professor of Clinical Pathology.

New appointments are:

James Baxter, Ph.D., appointed Assistant Professor, Psychiatry; presently Psychologist, Family Section, John Umstead Hospital, Butner, North Carolina.

Raphael Caffrey, M.D., appointed Instructor, Pathology; presently Instructor, Department of Pathology, St. Louis University School of Medicine, St. Louis 4, Missouri.

Jerome Cohn, M.D., appointed Assistant Professor, Medicine; presently Director, Pulmonary Physiology Laboratory, Veterans Administration Hospital, Salt Lake City 13, Utah.

Kenneth Dumars, M.D., appointed Assistant Professor, Pediatrics; presently Clinical Instructor, Department of Pediatrics, 809 Cascade Avenue, Colorado Springs, Colorado.

Roswell Fine, M.D., appointed Assistant Professor, Psychiatry; presently Assistant Superintendent, Psychiatric,

Sonoma State Hospital, Eldridge, California.

Mr. Donald Hochstrasser, appointed Instructor, Community Medicine; presently in the Department of Anthropology, University of Oregon, Eugene, Oregon.

Arthur Lieber, M.D., appointed Assistant Professor, Radiology; presently Staff Radiologist, Minneapolis Veterans Administration Hospital, and Chief of Radiology Unit, VA Center, Ft. Snelling, Minn.

Charlton Mabry, M.D., appointed Instructor, Pediatrics; presently Trainee of National Institutes of Arthritis and Metabolic Diseases, St. Christopher's Hospital, Philadelphia 33, Pennsylvania.

James Maddox, M.D., appointed Assistant Professor of Clinical Psychiatry; presently Deputy Medical Officer in Charge, United States Public Health Service Hospital, Lexington, Kentucky.

Nelson Thomas, M.D., appointed Associate Professor, Pediatrics; presently Assistant Clinical Professor, University of California, San Francisco, Calif., and Superintendent and Medical Director, Sonoma State Hospital, Eldridge, California.

Student AMA Chapter Launched at UK

Hoyt Gardner, M.D., Louisville, KSMA representative on the advisory committee to the University of Louisville chapter of the Student AMA, and Barney Elliott, a junior student at the U. of L. and immediate past president of its SAMA chapter, met with representatives of the faculty and student body of the University of Kentucky and members of the medical profession of Fayette County to help launch a Student AMA chapter at the new medical school in Lexington.

Joe Christian, a U. of K. student, has been named president of the new chapter, and William J. Moore will be secretary.

Richard H. Segnitz, M.D., is the KSMA representative on the advisory committee to the new chapter and Matthew C. Darnell, Jr., M.D., immediate past president of the Fayette County Medical Society, is representing his county on the committee. Both doctors are from Lexington.

UK Medical Center Receives Grants Totaling $97,000

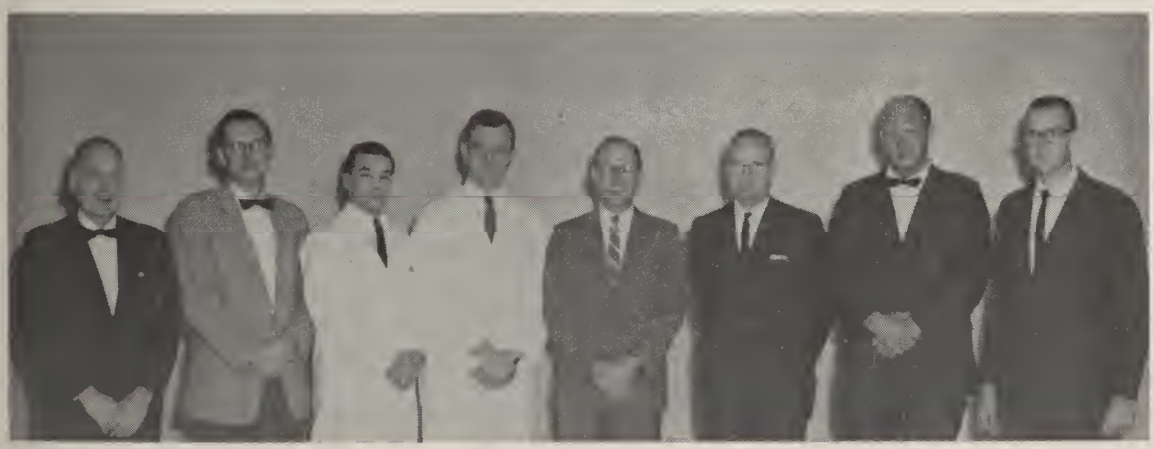
Grants totaling $97,000 have been received by the University of Kentucky Medical Center. The largest was a $32,000 grant from the National Institute of Health for investigation into the causes of "sudden and unexplained death." The research will be directed by Rudolph Muelling, M.D., of the department of pathology.

A $21,759 grant from the National Health Institute will be used under the direction of William Knisely, M.D., to investigate the anatomy, pathology and physiology of the living lung. Loren D. Carlson, M.D., will be the chief investigator under a $22,046 grant from the Aeronautical Systems Division, Wright-Patterson Air Force Base, to study the physiological mechanism involved in tolerance to aerospace flight environments.

Other grants were $7,107 by the National Tuberculosis Association for research by Herman Huempfner, M.D.; $6,350 from the Kentucky Heart Association for research by Edmund D. Pellegrino, M.D.; $6,210 from the National Institute of Health for research by William Waugh, M.D.; $1,650 from the Research Institute for the Study of Man for development of a community medicine case book project by Kurt W. Deuschle, M.D.; and several other gifts totaling $12,754.

Dr. Moore Receives Grant

Under an in-service training grant of $125 from the Southern Regional Education Board, Harry G. Moore, Jr., M.D., of the Louisville Child Guidance Clinic, spent two days at the Anderson School, Staatsburg-on-Hudson, New York, and Children's Village, Dobbs Ferry, New York. He observed diagnostic and treatment services for children at the two institutions.



Representatives from the faculties and student bodies of the Universities of Kentucky and Louisville, and other members of the medical profession of Fayette County met at Lexington to help start the new Student AMA chapter at the University of Kenucky. From left to right they are: Matthew C. Darnell, M.D., Lexington; Richard K. Noback, M.D., assistant dean of the U. of K. Medical School; William J. Moore, and L. J. Treciokas, students at the new medical school; Michael Wilson, M.D., a member of the U. of K. faculty; Hoyt Gardner, M.D., Louisville surgeon and professor of medical civics at the University of Louisville; Barney Elliott, immediate past president of the U. of L. chapter, and Joe Christian, new president of the U. of K. chapter.

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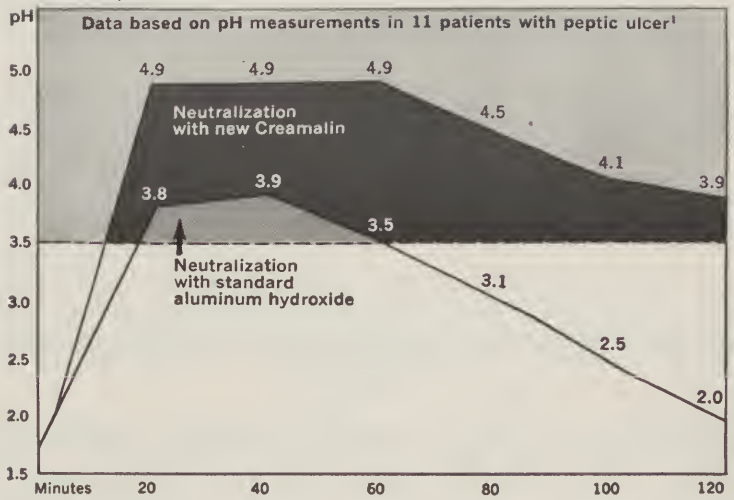
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Dosage: Gastric hyperacidity — from 2 to 4 tablets as necessary. Peptic ulcer or gastritis — from 2 to 4 tablets every two to four hours. Tablets may be chewed, swallowed whole with water or milk, or allowed to dissolve in the mouth. **How supplied:** Bottles of 50, 100, 200 and 1000.

1. Data in the files of the Department of Medical Research, Winthrop Laboratories. 2. Hinkel, E. T., Jr.; Fisher, M. P., and Tainter, M. L.: **J. Am. Pharm. A.** (Scient. Ed.) 48:384, July, 1959.

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Athletic Injury Prevention Conference Date Set

The third Annual Athletic Injury Prevention Conference will be held Saturday, August 12, at the Guignol Theater (Fine Arts Building) in Lexington. The Conference, under the sponsorship of the Kentucky State Medical Association in cooperation with the Kentucky High School Athletic Association, Kentucky Advisory School Health Council and the University of Kentucky Athletic Association, will be held in conjunction with the U. of K.'s annual coaching clinic.

Speakers and their subjects will be: John L. Wolford, M.D., Loiusville, "You Gotta Have Heart"; Owen B. Murphy, M.D., Lexington, "Don't Punt, Pass"; James E. Skaggs, D.M.D., Louisville, "Keep That Grin"; and George Gumbert, M.D., Lexington, "Save Those Joints."

The call to order and purpose of the meeting will be given by Carroll L. Witten, M.D., Louisville; and the official welcome will be given by Ted Sanford, Commissioner of the Kentucky High School Athletic Association.

This year's meeting falls on the day of the East-West Kentucky High School football and basketball games for charity.

Drs. Liu and Rehm Receive Grants for Advanced Study

Pinghui V. Liu, M.D., microbiologist, and Warren S. Rehm, M.D., professor of biophysics at the University of Louisville School of Medicine have both recently received grants for advanced study in their fields.

Doctor Liu received a $30,700 two-year grant from the National Institutes of Health for research on meningitis. His study will include research of ways to neutralize the listeria bacteria which he suspects releases toxic substances causing inflammation and could lead to an antitoxin vaccine.

Doctor Rehm is the recipient of a three-year grant of $62,400 grant from the National Science Foundation. He will make a study entitled, "Mechanism of Insulin Action on Invitro Frog's Gastric Mucosa.

Two New Buildings Set For UL Medical School

The University of Louisville has been granted a $2,997,000 loan to be used in building two new dormitories—one on Belknap campus and the other in the downtown Medical Center. The five-story Medical Center dormitory, which will cost about $1,542,000, will house 56 single men and 73 families according to U of L president Philip Davidson. He said it is hoped work on the building could begin in September or October, with occupancy aimed for the fall of 1962.

Property for the Medical Center building will be obtained by the City which has just completed the purchasing of land for the new medical-dental research building to be located in the same area. Construction on the seven-story building is slated to begin the end of June. A public campaign raised half the cost of the $2,800,000 building and the other half will come from matching federal funds.

The research building will be the first new building in the Medical School complex since 1935, when the present school building was erected. Its first six floors will be used for research space in surgery, obstetrics and gynecology, pediatrics, physiology, pathology, pharmacology, dentistry, and child development. The seventh floor will house the university's research animals.

First District Meet Held May 25

The annual dinner meeting of the First Trustee District was held May 25 at Kenlake, Hardin, announces Hugh L. Houston, M.D., Murray, trustee of the district. Henry B. Turner, M.D., associate of the Department of Obstetrics and Gynecology, University of Tennessee Medical School, was the featured essayist and presented a paper on "Cancer Detection and Treatment in the Female."

Pertinent Paragraphs

Meeting of Second, Third Districts Held May 26

Walter L. O'Nan, M.D., Henderson, and Ralph D. Lynn, M.D., Elkton, trustees respectively of the Second and Third Trustee Districts, report that 55 doctors attended a joint meeting of those two districts held May 26 at the Henderson County Club. W. H. Cave, M.D., Henderson, president of the Henderson County Medical Society, presided at the meeting.

Guest essayists were two members of the faculty of the University of Louisville School of Medicine: James B. Douglas, M.D., assistant professor of radiology, speaking on "X-Ray Helps for General or Specialty Practice"; and William Edward Oldham, M.D., assistant professor of obstetrics and gynecology, who presented a paper on "Child Birth After Endometriosis."

Joint Meeting Held June 1 For 12th, 15th Districts

The 12th and 15th Trustee Districts held a joint meeting June 1 at DuPont Lodge, Cumberland Falls, according to Thomas O. Meredith, M.D., Harrodsburg, and Keith P. Smith, M.D., Corbin, trustees respectively of the two districts.

Scientific essayists at the afternoon session were: John Q. Adams, M.D., associate professor of obstetrics and gynecology at the University of Tennessee Medical School, speaking on "Premature Separation of the Placenta"; and two members of the faculty of the University of Louisville School of Medicine, Margaret A. Limper, M.D., associate professor of pediatrics, who presented a paper on "Infantile and Juvenile Obesity"; and James R. Hendon, M.D., assistant professor of medicine and chief of the Section on Endocrinology, who talked on "Thyroid Troubles."

Charles B. Stacy, M.D., Pineville, showed slides of pictures taken on a trip to Africa.

PG Office Announces Listings of Courses for July—Oct.

The Postgraduate Medical Education Office regrets that two courses had to be cancelled for insufficient registrations. For the Pediatrics Course, to be held in Owensboro, only two physicians registered, representing hardly 1% of the potential physician population in this area. The Pulmonary Diseases Course, scheduled for Louisville, received only seven applications, or also less than 1% of the potential physician population of the area.

The above situation is all the more disappointing since the topics offered were requested by the majority in these respective areas according to a statistical survey that was made some time ago.

The following is a list of the programs offered in the State of Kentucky and states adjacent to Kentucky.

Detailed information may be obtained from the Postgraduate Medical Education Office, 104 West Chestnut Street, Louisville 2. The telephone number is JUniper 7-7135.

The complete listing follows:

JULY

Weekly through 1961	One week training in the field of OB & GYN, each week during 1961, with the exception of: October 2-7, and October 23-28; limitation to two physicians per week; fee $50 includes room at Louisville General Hospital, if desired; 42 hours of Category I Credit granted by the AAGP; enrollment should be made at least two weeks before desired participation.
13	Postgraduate course, "GENERAL MEDICINE," Harrodsburg, Beaumont Inn, 8:30 registration; 6 hours Category I Credit Approval by the AAGP.

AUGUST

16	KAGP Seminar; Cumberland Falls; E. C. Seeley, M.D., London, Chairman.
20	KAGP Seminar; Lexington, Kentucky.

SEPTEMBER

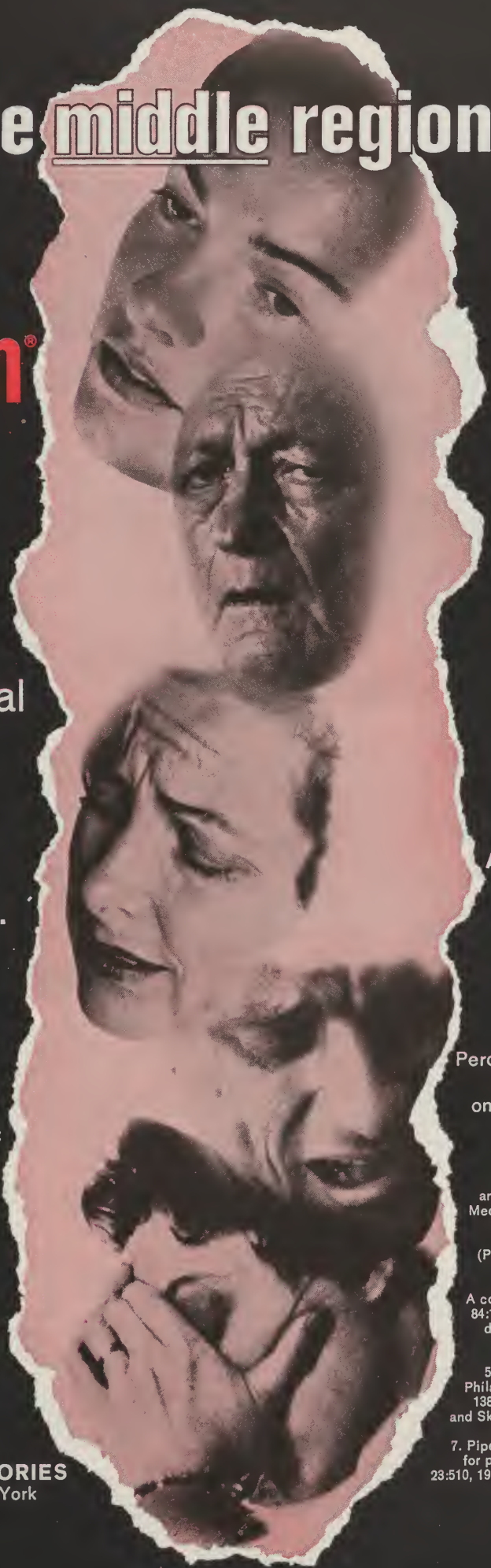
11-15	Eighth Annual Postgraduate Course on "Aviation Medicine"; Ohio State University, Columbus 10, Ohio, Dr. William F. Ashe, Chairman of the Department of Preventive Medicine.
18-23	Postgraduate course, "Changing Concepts of Cardio-Pulmonary Disease," Ohio State University, Columbus 10, Ohio, Dr. James V. Warren, Chairman of the Department of Medicine.
19-21	Annual Kentucky State Medical Association Meeting, Louisville.

OCTOBER

3	Postgraduate course, "Medicine," University of North Carolina, to be held at Morganton, N. C., afternoon and evening sessions.
4	Postgraduate course, "Medicine," University of North Carolna, to be held at Morganton, N. C., Afternoon and evening sessions.
5-December 21	Postgraduate Course, "X-RAY INTERPRETATION," Louisville General Hospital, 12 week intermittent program, to be held every Thursday evening.
5	Postgraduate course, "OBSTETRICS," (Tentative), one day program to be held in Paducah.
10	Postgraduate course, "Pediatrics," University of North Carolina, to be held at Asheville, N. C.; at afternoon and evening sessions.
11	Postgraduate course, "Pediatrics," University of North Carolina, to be held at Morganton, N. C.; at afternoon and evening sessions.
11-12	Postgraduate Course, "CHEST DISEASES," (Tentative), two day program to be held at the University of Kentucky Medical Center in Lexington.
15	Sixth Annual Session on Rheumatic Diseases, Ohio State University, Columbus 10, Ohio, Dr. F. W. McCoy, Director of Rheumatology Division.
17	Postgraduate course, "Surgery," University of North Carolina, to be held at Asheville; at afternoon and evening sessions.
18	Postgraduate course, "Surgery," University of North Carolina, to be held at Morganton; at afternoon and evening sessions.
19	Postgraduate Course, "RECENT ADVANCES IN THERAPEUTICS," (Tentative), a one day program to be held at Pikeville.
19	KAGP Seminar, Maysville.
24	Postgraduate course, "Medicine," University of North Carolina, to be held at Asheville; at afternoon and evening sessions.
25	John Walker Moore Seminar, Louisville Society of Internists, Dr. Stuart Graves.
25	Postgraduate course, "Medicine," University of North Carolina, to be held at Morganton; at afternoon and evening sessions.
25	KAGP Seminar, Mammoth Cave, Kentucky.
26	Postgraduate Course, "ANESTHESIA," a one day program to be held at Louisville General Hospital in Louisville.
27	Lexington Clinic's Annual Fall Clinical Conference, Campbell House Hotel, Lexington, Dr. John B. Selby.
30-November 24	Postgraduate course, "Psychiatry," Ohio State University Columbus 10, Ohio, Dr. Ralph M. Patterson, Chairman of the Department of Psychiatry.
31	Postgraduate course, "Medicine," University of North Carolina, to be held at Asheville; at afternoon and evening sessions.

Louis Hamman, Jr., M.D., who has practiced medicine in Cumberland for the past six years, will leave that city July 1. Doctor Hamman, a 1943 graduate of John Hopkins University School of Medicine, has accepted a position with a hospital in Hickory, N.C.

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Each Percodan* Tablet contains 4.50 mg. dihydrohydroxycodeinone HCl, 0.38 mg. dihydrohydroxycodeinone terephthalate (warning: may be habit-forming), 0.38 mg. homatropine terephthalate, 224 mg. acetylsalicylic acid, 160 mg. acetophenetidin, and 32 mg. caffeine.

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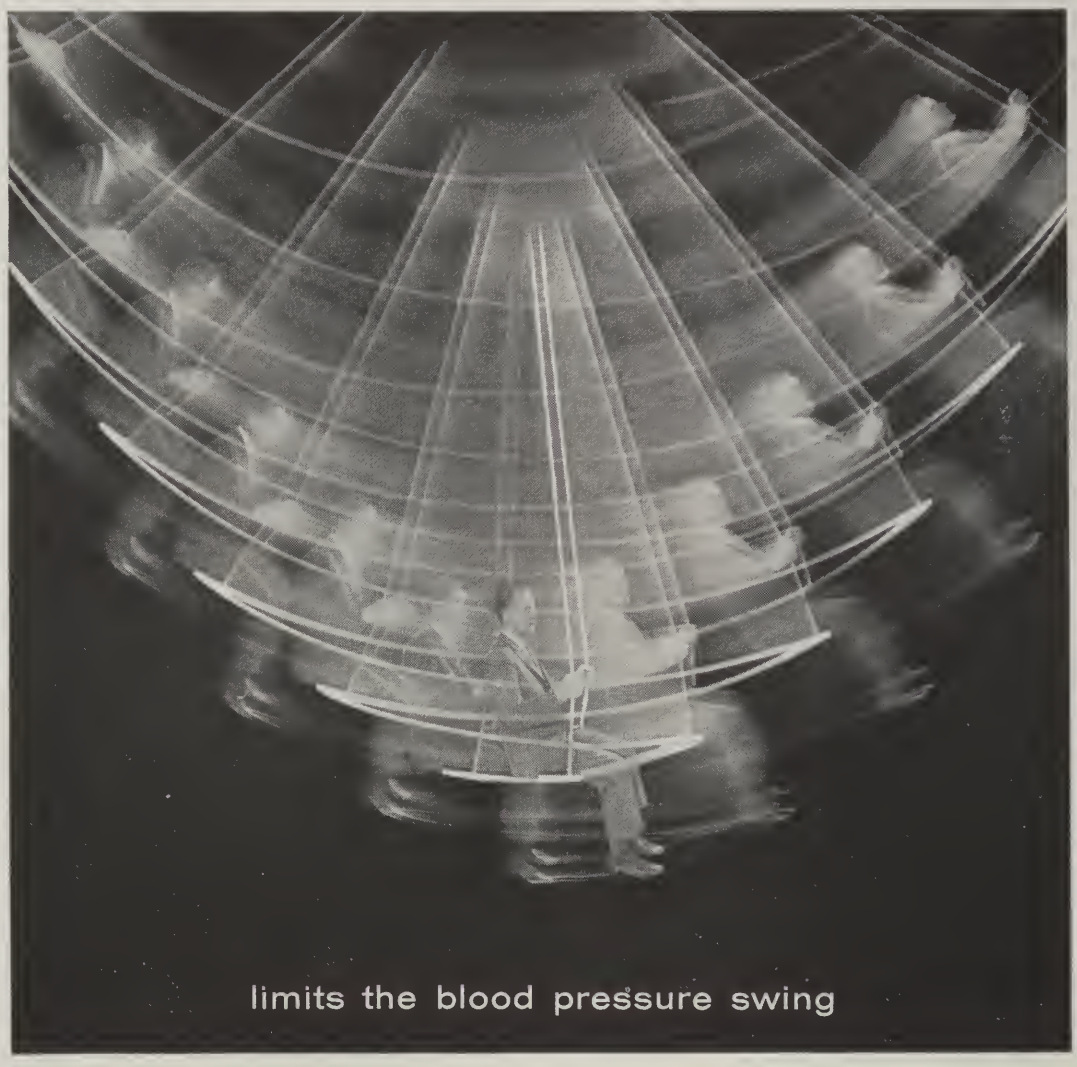
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1. Blank, P., and Boas, H.: Improved analgesia for moderate pain, Ann. West. Med. & Surg. 6:376, 1952. 2. Bonica, J. J., et al.: The management of postpartum pain with dihydrohydroxycodeinone (Percodan): Evaluation with codeine and placebo, West. J. Surg. 65:84, 1957. 3. Cass, L. J., and Frederick, W. S.: A controlled study in pain relief, M. Times 84:1318, 1956. 4. Chasko, W. J.: Pain-free dental surgery: Postoperative extension of the pain-free state, J. District of Columbia Dent. Soc. 31:3, No. 5, 1956. 5. Cozen, L.: Office Orthopedics, ed. 2, Philadelphia, Lea & Febiger, 1953, pp. 120, 138, 145, 156, 234. 6. Nicolson, W. P., Jr., and Skandalakis, J. E.: Control of postoperative pain, J.M.A. Georgia 46:471, 1957. 7. Piper, C. E., and Nicklas, F. W.: Percodan for pain in industrial practice, Indust. Med. 23:510, 1954; abstracted, Clin. Med. 3:1008, 1956, Current M. Digest 22:135, No. 3, 1955.

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At the May 15 meeting of the Citizens Commission on Aging held in Frankfort, the above pictured members were present. Seated from left to right are Mrs. John Serpell, Louisville, a member of the Commission; Governor Bert. T. Combs; and Chairman of the Commission, the Rev. H. Dix Archer, Cave City. Among others pictured are the following physicians: Harold McPheeters, M.D., Lousville, Commissioner of Mental Health; Russell Teague, M.D., Frankfort, Commissioner of Health; Albert S. Irving, M.D., Louisville; J. Duffy Hancock, M.D., Louisville; Ben Hollis, M.D., Louisville; and John Quertermous, M.D., Murray. The Commission was originally formed to work up factual data on aging in Kentucky for preparing material for the White House Conference on Aging. It is composed of approximately 25 members, all of whom have been appointed by the Governor. A plan is presently under study to be put before the 1962 Legislature that would make this a permanent body under statute regulations.

Henderson, Harrodsburg Sites of KAGP June Seminars

Two seminars sponsored by the KAGP were held during the month of June—one in Henderson and the other in Harrodsburg.

John M. Baird, M.D., Danville, presided at the Harrodsburg Seminar at the Beaumont Inn on June 7. Scientific presentations were made by George M. Gumbert, M.D., Carl H. Scott, M.D., and James R. Freedman, M.D., all of Lexington. Rex Knowles, Ph.D., spoke on "Medical Economics" at the dinner meeting.

The Henderson Seminar at the Henderson Country Club on June 22 had Robert Sumner, M.D., and Kenneth Eblen, M.D., as chairman and moderator respectively. Scientific essayists included: Edmund D. Pellegrino, M.D., Lexington; James E. Parker, M.D., Louisville; Harold W. Baker, M.D., Louisville, and H. William Clatworthy, Jr., M.D., Columbus, Ohio. A slide presentation on Italy was presented by Robert H. English, M.D., Henderson.

UK Dean On HEW Group

William R. Willard, M.D., vice-president of the University of Kentucky Medical Center, Lexington, has been named one of 22 members of the Surgeon General's Consultant Group on Nursing. Authorization for establishment of the group was given by President John F. Kennedy, in consultation with Secretary of Health, Education and Welfare Abraham Ribicoff.

The nursing profession is facing an acute shortage, and the demand for augmented and new services essential for an adequate health program promises to grow. The advice of physicians, hospital administrators, nurses, educators, social scientists and public health executives is being sought to help devise a program that will meet the needs of the Nation. Consultants are expected to report to the Surgeon General, Luther L. Terry, M.D., by January 1, 1962.

New Drug Firm Introduced at AMA

The introduction of a new drug manufacturing enterprise, Philips Roxane, Inc., to the American Pharmaceutical industry at the recent AMA meeting in New York set a historical precedent. The Philips Roxane exhibit at the meeting was purely institutional.

The company, which originated in the Netherlands is prominent in the electronic, pharmaceutical, and chemical fields. With headquarters in St. Joseph, Mo., the company's present products include a measles vaccine and a new progestational agent, both now undergoing extensive clinical trials. The Columbus Pharmacal Company of Columbus, Ohio, is an affiliate of Philips Roxane and will now operate under that name.

Alec Spencer, M.D., West Liberty, received a certificate of merit at Morehead State College commencement. The college made the award to Doctor Spencer and other members of the Eastern Kentucky Regional Development Commission for their work on the commission.

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In Memoriam

FRANCIS MARION SHERMAN, M.D.
Owensboro
1883 - 1961

Francis M. Sherman, M.D., Owensboro, a practicing physician for 55 years, died May 23 at Owensboro-Daviess County Hospital. A native of Butler County, he was a 1906 graduate of the University of Louisville School of Medicine.

Doctor Sherman began practice in South Carrollton in 1906, moving to Lewisport in 1914 and finally to Owensboro in 1924. In June 1959, the Daviess County Medical Association honored him with a gold pin for 50 years of service to the profession.

FRANCIS PRESTON THOMAS, M.D.
Hopkinsville
1873 - 1961

Francis Preston Thomas, M.D., a Hopkinsville physician for more than 65 years, died at his home June 5. He had been in critical condition since a heart attack on June 6.

A pioneer in the area as a specialist in childhood diseases, Doctor Thomas had ended his office practice in 1956 after falling and fracturing a hip. He continued to treat former patients at his home until 1959.

He received his medical degree from the Louisville Medical School in 1894 and began practice in Hopkinsville that same year. He served as a medical officer in Army hospitals in France during World War 1.

County Society Reports
Daviess County

New officers elected at the May 23 meeting of the Daviess County Medical Society are: William J. Oldham, M.D., president; William McManus, M.D., vice-president; and John D. Lovett, M.D., secretary-treasurer. All are residents of Owensboro and took office on June 15.

The regular meeting date of the Society is the fourth Tuesday of each month, September through May.
Organization

OB-GYN Society Holds Election

William H. Parker, M.D., Owensboro, was elected president of the Kentucky OB-GYN Society at its meeting at the Netherlands-Hilton Hotel, Cincinnati, May 18-20. Other officers elected were: vice-president —George G. Greene, M.D., Lexington and secretary-treasurer—Charles E. Hornaday, M.D., Owensboro. A paper on "Side Symptoms of Pregnancy" was presented by Clinton M. Lacy, M.D., Owensboro, at the meeting. The next annual meeting will be held in Owensboro.

Application

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Columbia Auditorium — **Louisville, Kentucky** — **September 19, 20 and 21**

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J. THOMAS GIANNINI, M.D., Chairman

Committee on Scientific Exhibits

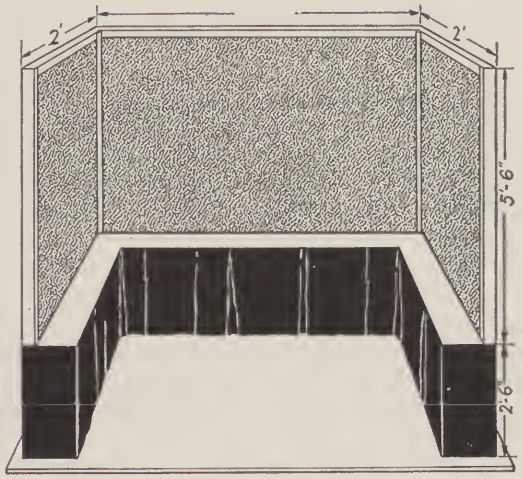
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2. Description or nature of exhibit: (Attach brief description to this blank).

3. Will you require shelf space? .....

4. Give approximate amount of wall space needed. (Included in total space is two side walls of two feet in length) .....

5. Name of institution co-operating in the exhibit (if desired) .....

6. Name of exhibitor: .....

..... (Street & No.) ..... (City)

The Kentucky State Medical Association will provide without cost to the exhibitor the following: Exhibit space, shelves, sign for booth, current, bracket lights, provided all items are approved in advance by the committee.

Cost of transporting exhibits to the meeting must be borne by the individual exhibitor as well as costs of cards, signs, etc., which are a part of the exhibit.

View boxes, furniture, decorations, etc., may be rented, if desired, by applying directly to Jos. T. Griffin Company, 704 West Main Street, Louisville 2, who supply equipment for the annual K.S.M.A. meeting.

Committee, Council Reports

KSMA Hospital Committee

J. B. Holloway, M.D., Chairman

Louisville **June 1, 1961**

The KSMA Hospital Committee held its second meeting of the associational year and most of the discussion centered on recommendations that the committee would be making to the Council on Medical Education and Hospitals.

There were three general recommendations and these were as follows:

1. A proposal that a committee composed of both KSMA and KHA members give further study to the licensing laws in Kentucky for hospitals and to see how they compare with those of other states and to further see if there should be any strengthening of these laws.

2. A recommendation that a procedure such as the Texas "Dry Run" program be initiated by the KSMA in cooperation with the KHA and that these "Dry Run" teams be available to any hospital that would like assistance of this sort. The purpose of the "Dry Run" teams is to give the hospital a sample of the procedures and requirements necessary to receive accreditation by the Joint Commission on Accreditation.

3. A recommendation that legislation be introduced in the 1962 General Assembly which would define the ownership of hospital charts, what constitutes a hospital chart, and also what portion of the information on the chart should be released to the general public and that any legislation along this line should be done with the approval and cooperation of the Kentucky Hospital Association.

KSMA Advisory Commission to Blue Shield

W. Vinson Pierce, M.D. Chairman

Louisville **May 18, 1961**

Copies of the first issue of the new Blue Shield Newsletter, to be mailed May 21 to doctors, hospitals, county farm bureau agents and the Blue Cross-Blue Shield staff, were distributed to the group. It was also reported that the June issue of The Journal would carry the first Question and Answer Page.

The chairman stated that the Indiana Plan could not be presented at the April 15 meeting of the Board of Trustees because of the many other items on the agenda and his own inability to be present at the meeting. A discussion followed and it was brought out that the proposed plan was not mandatory. The problem of controls was also discussed.

It was brought out that the Council on Communications and Public Services and House of Delegates were not in complete agreement regarding physicians listing full fees on the Blue Shield Claim form, therefore this recommendation has not been implemented.

Mr. Don Giffen reviewed the proposal of expanded coverage presented at the March 16 meeting so that recommendations could be made by the Commission to the Board of Director of the Kentucky Physicians Mutual.

Minor surgery performed in doctors' offices was discussed and it was moved that the Blue Shield staff study the possibility of an allowance for materials used in this performance and report to the Commission.

KSMA Council on Medical Services

Claude C. Waldrop, M.D., Chairman

Louisville **May 18, 1961**

A specially called meeting of the Council was held in the Blue Cross-Blue Shield Building on May 18, to consider actions taken by the KSMA Advisory Commission to Blue Shield.

Extended coverage riders developed by the Blue Shield staff were discussed and their proposals accepted by the Council.

The so-called "Indiana plan" was discussed and also adopted by the Council. Briefly, this plan involves the agreement of the members of a county medical society to accept as fixed payment preferred benefits offered to hourly wage employees up to certain limits, unless the individual physician discusses the fee with the patient prior to rendering the service. The plan also calls for a district grievance committee to adjudicate claims unless the local county is large enough to have its own.

Following a discussion of the reasons why the Advisory Commission had recommended to the House of Delegates in 1960 that all physicians list fees on Blue Shield forms, the Council moved that the request be supported by the Council.

Council on Medical Education and Hospitals

Walter S. Coe, M.D., Chairman

Louisville **May 18, 1961**

The Council on Medical Education and Hospitals, at its second meeting of the association year, heard Glen Leymaster, M.D., with the AMA Council on Medical Education and Hospitals, discuss the role the AMA Council plays on the national level. This report covered the area of Postgraduate Medical Education, the ECFMG program, undergraduate education and its relationships with services closely allied to medicine.

Also present was William R. Willard, M.D., Lexington, Dean of the University of Kentucky Medical Center and a member of the AMA Council on Medical Education and Hospitals. Doctor Willard listed several suggestions that the KSMA Council might pursue in expanding its activity.

Reports were presented covering the activities of the committees during the year by the committee chairmen who were present and plans were made toward the final formulation of the annual report to the Board of Trustees for the House of Delegates' approval.

Pertinent Paragraphs

The University of Illinois College of Medicine Department of Otolaryngology will offer an intensive postgraduate basic and clinical program under the direction of Doctor Emanuel M. Skolnik, September 23-30. This Annual Otolaryngologic Assembly offers a compact program of one week of daytime and evening sessions designed to bring to specialists a wide variety of current advances in management, therapy and philosophies. Review of basic morphologic features under the direction of Maurice F. Snitman, M.D., and Frederic J. Pollock, M.D., is also included, and will feature laboratory demonstrations, dissection and prosection, all augmented by visual aids. Interested physicians should write the Department of Otolaryngology, University of Illinois College of Medicine, 1853 West Polk Street, Chicago 12, Illinois.

The Medical Care Research Center, an agency of the Social Science Institute of Washington University and the Jewish Hospital of St. Louis, announces an Institute on Home Care to be held July 31, August 1 and 2, at the Jewish Hospital of St. Louis. The Institute is sponsored by the United States Public Health Service with the cooperation of the Missouri Division of Health, the St. Louis Department of Health and Hospitals, the St. Louis County Health Department, and the Health and Welfare Council of Metropolitan St. Louis. For further information and registration, write the Home Care Institute, Medical Care Research Center, 216 South Kingshighway, St. Louis 10, Missouri.

Reprints of four combined clinical staff conferences of the National Institutes of Health, published in the Annals of Internal Medicine, are now available to interested physicians upon request. They are: "Unexplained Death in a Patient With Leukemia," vol. 53, no. 6, Dec. 1960; "Recurrent Pulmonary Disease in a Child," vol. 53, no. 3, Sept. 1960; "Problem in Differential Diagnosis," vol. 52, no. 6, June 1960; "Primary Amyloidosis," vol. 52, no. 3, March 1960. For reprints, write the Clinical Center Information Office, National Institutes of Health, Room 1-N-226, Bldg. 10, Bethesda 14, Maryland.

The number of physicians in the United States increased 4,330 last year according to the annual report of the AMA council on medical education and hospitals. The report showed that 8,030 physicians received their first licenses and 3,700 died during the year. There were 252,049 registered physicians in the U. S. at the start of 1961. The increase in the physician population in 1959 was 4,769.

The Southeastern Surgical Congress announces that residents of approved hospitals in the southeastern states are eligible to enter its contest for the best scientific papers. Papers are due before December 1, 1961, at the Congress office, 340 Boulevard, NE, Atlanta 12, Ga. First prize is an all-expense paid trip to the meeting at Louisville, March 5, 6, 7 and 8, 1962, plus a cash award.

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Clinical Director

Graduating Class Honors Faculty

Three members of the University of Louisville School of Medicine were honored by its 83-member graduating class at an honors convocation on May 23. K. C. Huang, M.D., associate professor of pharmacology, was named the best preclinical instructor (years one and two) for the third time. J. Alex Haller, Jr., M.D., assistant professor of surgery, was chosen the best clinical instructor (years three and four); and James F. Williamson, M.D., a third year resident in obstetrics, was selected as the best resident physician.

Blue Shield M.D. Payments Up

During 1960 the medical profession received more than $731,000,000 from 74 nationwide Blue Shield Plans for care rendered members, according to the National Association of Blue Shield Plans.

This figure represented an all-time high for a one-year period and was nearly 90 per cent of the total 1960 income of the medical-surgical plans. The report indicated that Blue Shield payments to physicians had increased from nearly $116,000,000 in 1950 to the 1960 figure of $731,131,187.

Heart Assoc. Elects New Officers

Marc J. Reardon, M.D., Covington, president of the Kentucky Heart Association was re-elected for a second term at the association's Board of Directors meeting on June 8. Re-elected first vice president was Richard R. Crutcher, M.D., Lexington. George W. Pedigo, Jr., M.D., was elected vice president. Three physicians were re-elected to three-year terms on the Board of Directors. They are: Doctor Crutcher, J. Murray Kinsman, M.D., Louisville, and Frank H. Moore, M.D., Bowling Green.

Hospital Pharmacists Organize

Hospital pharmacists in Kentucky formed a professional group at a meeting at the University of Kentucky Medical Center, May 26. Joseph Oddis, national executive secretary of the American Society of Hospital Pharmacists, helped to organize the Kentucky chapter. He spoke on "The Role of Affiliated Chapters in Hospital Pharmacy Progress." Professional papers were given by Z. S. Gierlach, M.D., and Charles Walton, M.D., both of Lexington.

Hospital Named Training Center

Western State Hospital, Hopkinsville, has been designated by the American Psychiatric Association as a regional training center for its "remotivation program," a new and unusual group technique that is aiding in the rehabilitation of mentally ill patients.

Robert S. Garner, M.D., chairman of the association's committee on remotivation said that Western State is the fifth regional training center set up thus far and will serve as headquarters for teaching the technique to personnel in all four of Kentucky's state-operated mental hospitals.

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News Items

Ian Keith Edwards, M.D., a native of Spartansburg, S. C., has begun practice at the Trover Clinic, Madisonville, where he will limit his practce to obstetrics and gynecology. Doctor Edwards is a 1952 graduate of Duke University. He interned at Walter Reed Army Hospital and took his residency at Grady Memorial Hospital, Emory University, Atlanta, Ga. He was with the Army Medical Corps for eight years in which he held the rank of captain. He was previously Chief of OB-GYN Service, Valley Forge General Hospital, Phoenixville, Pa.

Harry C. Denham, M.D., Maysville, was recently installed as president of the University of Kentucky Alumni Association. He is a former member of the U of K Board of Trustees. **Glenn U. Dorroh, M.D.**, Lexington, was named to the executive committee. **George Estill, M.D.**, Maysville and **C. C. Lowry, M.D.**, Murray, were appointed by Doctor Denham to serve one-year terms as UK alumni directors.

Dillard D. Turner, M.D., London, has been named Director of Public Health for the four counties of Crittenden, Caldwell, Livingston and Lyons. A 1934 graduate of the University of Louisville School of Medicine, Doctor Turner returned to his native Leslie County after graduation to become its Director of Public Health. He was transferred to Perry County and later began private practice in Clay County. His present headquarters are in Marion.

Mitchell B. Denham, M.D., Maysville, chairman of the KSMA Committee on Rural Health and state representative from the 65th District, was chosen as Maysville's outstanding citizen by the local high school Hi-Y club.

William C. Christopherson, M.D., Louisville, professor and chairman of the department of pathology of the University of Louisville School of Medicine, will give a talk in Vienna at the First International Cytology Conference to be held August 31-September 2. His talk, entitled "A Study of the Reversibility of Dysplasia of the Uterine Cervix," is a report on an experimental study done on animals over a four year period. Doctor Christopherson will also spend ten days visiting the Danish Cancer Registry in Copenhagen and will visit the department of pathology of the University in Vienna. His plans for travel during a sabbatical leave to begin September 1962, are indefinite.

Emily S. Warfield, M.D., Lexington, was presented with a silver julep cup in appreciation of her 25 years as clinician at the Planned Parenthood Clinic at the Good Samaritan Hospital, Lexington. Doctor Warfield has been at the clinic since it was founded by Mrs. Samuel Walton and **Josephine D. Hunt, M.D.**, Lexington, who are now honorary board members. The presentation was made by Mrs. Irving Rosenstein, president of the Planned Parenthood Clinic.

Clair Gilbert Prindle, M.D., Maysville, is terminating his practice in that city to accept the position of medical director with the Travelers Insurance Company at its home office, Hartford, Conn. A 1937 graduate of the Temple University College of Medicine, Philadelphia, he interned at St. Vincent Hospital, Erie, Pa., and took his residency at Taunton State Hospital, Taunton, Mass. Doctor Prindle began practice in Maysville in 1939.

Donald Chatham, M.D., Shelbyville, has been elected president of Georgetown College alumni. A 1948 graduate of Georgetown College, he has served on its alumni advisory board since 1956. Doctor Chatham was named president in the school's first national election of officers. He received his medical degree from the University of Louisville School of Medicine in 1952.

Gabe A. Payne, Jr., M.D., Hopkinsville, is moving to Nashville, Tenn., for a year's study at Vanderbilt University School of Medicine where he received his medical degree. Doctor Payne needs only nine months more of study to qualify for the American Board of Pediatrics, after which he will return to Hopkinsville.

C. V. Hiestand, M.D., Campbellsville, thought to be the oldest practicing physician in Kentucky, was guest of honor at a reception held at the Taylor County Health Department on May 25. He celebrated his 90th birthday on May 26. An 1896 graduate of the Louisville Medical College, Doctor Hiestand began practice in Merrimac, later moving to Campbellsville.

James R. VanArsdall, M.D., has recently begun practice in association with the Fuller-Morgan Hospital and Clinic in Mayfield where he will limit his practice to ophthalmology. Doctor VanArsdall is a 1952 graduate of the University of Tennessee College of Medicine. He interned at Knoxville General Hospital and took his residency training at the Gill Memorial Eye, Ear and Throat Hospital, Roanoke, Va. He had a general practice in Sevierville, Tenn., before going to Roanoke.

Lloyd Porter May, M.D., Fort Thomas, has left his post as Kenton County Health Officer to take a new job as commissioner for public health in a four-county area of Ohio. A 1953 graduate of the University of Louisville School of Medicine, Doctor May came to Fort Thomas in 1957, succeeding H. C. White, M.D., who had resigned in 1956.

Dewey E. Cummins, M.D., Nicholasville, left that city in June to begin practice in Brooksville, following the retirement of B. F. Workman, M.D.

James E. Hamilton, M.D., Murray, has been named health officer for Hickman, Fulton and Carlisle counties. Doctor Hamilton, who graduated from the University of Louisville School of Medicine in 1958, has been associated with the Murray Community Hospital.

1962—Will Your Taxes Be Higher?

On April 20, 1961, President Kennedy appeared before Congress and presented his tax program calling for early approval of new tax credits to spur business investment in new plants and equipment. He said his proposal would save businessmen and cost the government approximately $1.7 billion in taxes a year.

To recoup each year's revenue loss fully after the third year, the President also suggested revisions designed to collect tax from persons receiving dividends and interest, businessmen with large expense accounts, businesses operating abroad and other groups of taxpayers. Numerous other revisions were also proposed which will not be discussed here as they would not be of much general interest to physicians.

Some of these provisions, assuming they are enacted, will affect you as a practicing physician and taxpayer. For example, let's look at his proposal to repeal the 4% dividend credit and the $50 dividend exclusion. Presently, any dividends received by you on stock owned may be excluded from your federal tax return up to the amount of $50. If a joint return is filed with your wife and both husband and wife have dividend income, each one may exclude $50 received from qualifying corporations, but you may not use any portion of the $50 exclusion not used by the other. The President has asked for a repeal of this provision because this is not an efficient way to encourage equity capital formation, this credit favored dividend recipients in the high income brackets and this mechanism further favored all stockholders over taxpayers who received their income from wages and other sources.

Translating this suggested repeal into terms of dollars, this could cost you, assuming the filing of a joint return, at least $100 jointly owned dividends; an additional $20 in taxes at the minimum rate of 20%. The higher your income tax bracket, the greater increase in your tax liability. Also, the 4% dividend credit, if repealed, will further increase your liability.

Another proposal in the Kennedy program was that a 20% withholding tax, effective January 1, 1962, be imposed on dividends and on interest paid on savings bonds and other taxable Government bonds, corporate bonds, savings accounts and similar items of income. This would tend to subject this income to withholding similar to the withholding now on wages received by employees.

Any organization paying dividends or interest would withhold 20% of each payment. A bank cashing a government savings bond would withhold 20% of the interest portion. These organizations would then forward the 20% withheld to the Treasury periodically through the year. Each taxpayer would then, for tax purposes, at the end of the year adjust for this withholding as a credit against the tax liability indicated on his federal tax return.

Also, the President proposed disallowing many present business expense account deductions in an effort to eliminate "widespread abuses." In later hearings before the House Ways and Means Committee, Secretary of the Treasury, Dillon, called for legislation that would include a $30-a-day limit on a businessman's away-from-home living costs. Transportation would continue to be fully deductible outside the $30 limit. Secretary Dillon further recommended that deductions for club dues, entertainment at night clubs, country clubs, hunting and fishing trips be eliminated.

Legislation should also be enacted, the President said, so that each taxpayer starting in January 1962 would be given an account number to help the Internal Revenue Service use automatic equipment to check tax returns. This number would be required on each taxpayer's return and supporting data. Taxpayers having social security numbers would use them as their "taxpayer account number," and other taxpayers would be assigned numbers. To keep pace with the number and complexity of returns filed, the Administration has asked for $34 million to hire 4,265 additional workers.

The above is only a part of the sweeping tax message voiced by the President, who promised to send a far more comprehensive tax revision plan next January. The 1962 program would probably move in the direction of a broader tax base and lower tax rates.

Will this program as proposed by the Kennedy administration be adopted by Congress? Only time will tell. Congress is likely to look with favor upon some type of investment incentive form for business, although not necessarily Mr. Kennedy's plan and may balk at some of his revenue raising proposals.

Some of these proposals can mean additional dollars for you to pay effective January 1, 1962. In the meanwhile, watch the papers and see how this program fares. Businessmen throughout the nation have already reacted vehemently to the expense account proposal.

We, as citizens, should all be alert and aware of measures that affect us as tax-paying individuals.

William E. Rudd



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RESUSCITATION OF THE NEWBORN INFANT: edited by Harold Abramson; M.D.; published by The C. V. Mosby Company, St. Louis, Mo.; 274 pages; price, $10.

This is a most unique volume to which more than twenty distinguished teachers and clinicans have contributed. The editor deserves praise for the orderly manner in which the subject matter is prersented. A splendid review of circulatory and respiratory physiology is given. Considerable space is spent on experimental studies done in animals and this is informative and interesting. One is reminded, however, and wisely, that caution must be exercised in implying that a pattern of change or a reaction in one animal will be identical to that occurring in another species because the two animals may be the same age. There is considerable difference in maturity at birth in some animals and in the human.

Causes of perinatal disability in relation to respiratory insufficiency is discussed in detail and most intelligently. The diagnosis and management of obstetric factors that give use to asphyzia are excellently covered. The use and value of fetal electrocardiography is given proper coverage.

The highly vital first sixty seconds of life are discussed thoroughly. Methods of evaluation of the newborn at this time, the intelligent methods of resuscitation and accepted therapeutic procedures are clearly narrated and illustrated.

Many popular methods of resuscitation that are valueless and even harmful are reviewed. The conduct of a newborn nursery is outlined and this chapter would be most rewarding for those charged with the responsibility of caring for the premature as well as for the mature newborn.

Despite its brevity this book was at times tedious reading for this reviewer because of the detail, especially the results of animal experimentation. It makes one realize, however, that those of us so occupied with clinical medicine, overlook at times what the research worker in basic sciences is accomplishing and contributing that often is responsible for giving life to a life.

All concerned with delivery of a newborn will benefit by reading this book. The anaesthesiologist, who should lead in programs of resuscitation will be most highly benefited particularly by having this volume for reference.

The obstetrician, pediatrician and general family specialist should all be conversant with the contents of "Resuscitation of the Newborn Infant."

This reviewer repeatedly felt that he was reading and learning from competent, dedicated men of science. Each contributor should be commended and offered sincere appreciation for a concise, compact contribution to his colleagues' medical library.

Edwin P. Solomon, Jr., M.D.

THE QUESTION OF FERTILITY; by Georges Valensin, M.D.; published by Doubleday & Company, Garden City, N. Y.; 296 pages; price, $4.50.

This is a well written book concerning the problems of fertility. It might well have been titled "The History of the Study of Fertility." It is clearly written and could easily be understood by the general reader.

The material covered in this book deals with the causes of sterility in both the male and female. The moral, legal, and biological aspects of artificial methods of overcoming sterility are discussed in great length.

To the physican much of the material presented is of interest since many of the past concepts in sterility work are presented which are not universaly in acceptance today. This is particularly true in the discussion of the causes of sterility.

This book is recommended to medical students and those entering the field of fertility work as a good background into the subject. It also can be recommended to the general reader who might have some interest in this subject. Certainly the specialist who works with the problems of fertility would have no use for this book other than for historic interest; however the author does present more recent work but not in detail.

Ray Potts, M.D.

STROKE: edited by Douglas Ritchie; published by Doubleday and Co, Inc., Garden City, N. Y., 1961; 192 pages; price $3.50.

This is the personal account of the author's battle with a stroke. Douglas Ritchie was a prominent BBC commentator when his busy life was abruptly altered by major cerebrovascular damage on the dominant right side.

The busy physician who may have fallen into the habit of stereotyping his thinking and treatment of stroke patients should read this book. Patients especially should benefit from the determination demonstrated by this unusual man.

The author's description of his frustration during the first few days of visual impairment and hemiplegia

(Continued on Page 712)

Answers to Questions About Your BLUE SHIELD

Q.—What are some differences between the allowances for procedures of the Standard and Preferred Blue Shield Plans?

A.—The Preferred Blue Shield has a higher scale of allowances than the Standard plan. For instance—

Procedure	Standard	Preferred
Total Gastrectomy	$225.00	$300.00
Radical mastectomy-bilateral	225.00	250.00
Caesarean section	100.00	150.00
Appendectomy	100.00	150.00
Pregnancy and Child Birth	50.00	90.00
Tonsillectomy and Adenoidectomy	30.00	40.00

Q.—What are the maximum allowances under Standard and Preferred Blue Shield?

A.—Up to $225 maximum under the Standard; up to $300 maximum under the Preferred.

Q.—What is provided on the hospital medical indemnity rider, sometimes known as the Hospital-Medical Rider?

A.—Endorsement No. 1 provides that members who receive Medical Services on non-surgical cases from a medical doctor in an approved general hospital will, beginning on the fourth day of such hospitalization and continuing up to twenty-seven (27) days, receive an indemnity allowance of $5.00 per day up to a maximum of $135.00 in any one contract year.

Endorsement No. 2, which is held by many subscribers, provides for payments of $5.00 beginning on the first day of hospitalization and continuing up to 30 days, up to a maximum of $150.00 in any contract year.

Medical Services are defined as services which do not involve:

(a) Operative of cutting procedures for the treatment of disease or injury.

(b) Treatment of fractures, dislocations or other accidental injury.

(c) Obstetrical procedures including prenatal or postnatal care.

Q.—What is the cost of Standard Blue Shield per month for a family through a group compared to those billed on a direct or non-group basis?

A.—Group family dues are $2.50 a month and direct billing dues are $3.00 a month, however, members paying direct are billed every quarter.

Q.—What is the cost of Preferred Blue Shield for a family per month through a group compared to those billed on a direct or non-group basis?

A.—Group dues are $4.60 family, and the dues on a direct billing basis are $5.10 a month. Members who are direct subscribers are billed on a quarterly basis.

Q.—Has Blue Shield ever cancelled a member because of age or physical condition?

A.—No. Members may retain their protection regardless of age or physical condition.

Q.—I am retired. If I die, can my wife, who has a heart condition, continue her membership?

A.—Yes, she may continue her membership in good standing on a single contract for as long as she lives.

Q.—What is a Blue Shield contract year?

A.—The term "contract year" shall be the period from the effective date, which is the day of the month on which the protection becomes effective, to the corresponding day of the succeeding calendar year.

Q.—Why does the contract refer to a contract year?

A.—The contract year is the period for determining maximum payment the member is eligible for in a 12-month period.

Q.—What is a Blue Shield Group Leader?

A.—The term "group leader" means the employer or person designated in a group to handle enrollment of employees in the firm, see that dues are collected and paid to the Plan, and handle any problems that may develop with Kentucky Physicians Mutual, Inc., for the members of that particular group.



From the files of the COMMITTEE FOR THE STUDY OF MATERNAL MORTALITY



CASE #88—A 26-year-old white gravida 4 para 3 whose expected date of delivery was January 13, 1960, first consulted her physician at seven months gestation, returning thereafter for 5 return prenatal visits.

Months of Pregnancy	1	2	3	4	5	6	7	8	9 (1)	9 (2)	9 (3)
Blood Pressure							120	120	124	120	
							70	70	70	68	
Weight							166	168	168	166	
Urine							Neg	Neg	Neg	Neg	

RH+; VDRL nonreactive

The patient gave a past history of epilepsy, but the proctocol made no mention of current medication. She had been treated by cervical cauterization once in the indefinite past.

The prenatal course was uneventful except for a slight upper respiratory infection on December 17. This responded to simple symptomatic treatment.

The patient was admitted to the hospital at 12:30 a.m. on December 29, 1959, having irregular uterine contractions. The blood pressure was 118/78. Since vaginal examination revealed no dilation of the cervix, the patient was given a liquid diet and placed under observation. At 7:00 a.m., the cervix was one finger dilated; the blood pressure was 120/80, and the fetal heart rate was 128. A dextrose infusion was started, and morphine was administered. At 2:00 p.m. there were no uterine contractions according to the nurses' notes. At 5:30 p.m. the same dilation persisted, and there was some seepage of amniotic fluid. The fetal heart rate was regular and of good quality. Seconal was administered for sedation.

At 9:00 a.m. on December 30, 1959, contractions were recurring at seven minute intervals. Rectal examination at 10:00 a.m. showed questionable beginning cervical dilation, with contractions every 3 or 4 minutes. At 11:00 a.m. vaginal examination showed the cervix to be still only one finger dilated. The status of the membranes was not mentioned. A consultant recommended a low cervical cesarean section because of the history of cervical cauterization.

Under the cyclopropane and sodium pentothal anesthesia, a low cervical cesarean section was performed with delivery at 12:22 p.m. of a living female infant weighing 7 pounds. After manual removal of the placenta, the uterus was closed using three layers of chromic catgut. An elective appendectomy was done and the abdomen was closed. The patient reached the recovery room in good condition.

At 1:30 p.m. the patient was described as resting. The blood pressure was 104/70, the pulse 120 and respirations 20. She was given 1/8 grain of morphine intravenously at this time and at 3:30 p.m. was returned to her room in good condition. The blood pressure at this time was 120/78, the pulse 98 and respirations 20. She was given 100 mg demerol intramuscularly at 3:30 p.m. for pain. At 5:30 p.m. the nurses' notes state that the patient was turning and coughing. A dilute pitocin infusion was administered although no mention was made of increased vaginal bleeding, or of the blood pressure at that time. At 7:30 p.m., the patient was nauseated; she was given 25 mg of phenergan and 50 mg of demerol. Her physician saw her and noted that her condition seemed satisfactory.

At 11:00 p.m., the patient was cold, clammy and cyanotic, and was perspiring profusely. The blood pressure was 104/76, pulse was 120 and the respirations were counted at 40 per minute. A blood count showed a red count of 5,290,000, 15.2 grams of hemoglobin and a hematocrit of 46 volumes per cent. As a glucose infusion was started, the blood pressure was 84/60, and the pulse was 140 and weak. The foot of the bed was elevated and external heat was applied to the patient. At 11:25 p.m., the blood pressure was 86/62. One ampule of digifolin was given intravenously at 11:45 p.m. The patient's color had improved slightly at 12:05 a.m., but hypotension and tachycardia persisted despite repeated administration of digitalis and levophed.

A medical consultant was called. The blood pressure was unobtainable and the radial pulse was very weak. Bronchial vesicular breath sounds partially obscured the heart tones; no moist rales were heard. The abdomen was soft and there was no hepatic enlargement or excessive bleeding. The patient was alert, apprehensive and thirsty. An emergency electrocardiogram showed right axis deviation with clockwise rotation of the heart, together with supraventricular tachycardia. The consultant's impression was one of peripheral circulatory collapse, possibly caused by viral myocarditis, adrenal insufficiency, pulmonary embolus, electrolyte insufficiency, or internal bleeding.

At 6:20 a.m., a cut down was done. Respirations were grunting, with a rate of 42 per minute. The heart rate was 140. At 7:25 a.m. she was given a .25 mg of lanoxin. No blood pressure or pulse could be felt at 8:45 a.m. An apical heart rate around 160 was counted; .25 mg lanoxin was given intravenously together with 10 cc of 10 per cent calcium gluconate and positive pressure oxygen with the Bennett machine.

At 11:15 a.m. the patient no longer responded to external stimuli. She was pronounced dead at 11:18 a.m., 22 hours postpartum. It was noted that she had

(Continued on Page 712)

Pertinent Paragraphs

Harry S. Gear, M.D., an eminent international medical leader in the field of hygiene and tropical medicine, will become Secretary General of the World Medical Association on July 1. Dr. Gear has been the director of pneumoconiosis research, Council for Scientific and Industrial Research—Industrial Medicine in Johannesburg, South Africa. He received his education at the Universities of Witwatersrand and London; engaged in general practice in London, Rhodesia and South Africa, and had hospital and clinic experience in China, the Middle East and Africa.

More than 11,000 surgeons and physicians from all over the United States, Canada, and many foreign countries are expected to attend the five-day meeting of the 47th annual Clinical Congress of the American College of Surgeons in Chicago October 2-6. Approximately 1,000 doctors will take part in the program of nine postgraduate courses, 258 new research reports from medical centers throughout the country, 68 medical motion pictures, 26 cine clinics, 14 operative telecasts from Billings Hospital of the University of Chicago, and 300 scientific and industrial exhibits.

To give mental health personnel a chance to observe and study new or different methods of operaton in other states, the Southern Regional Education Board is offering individual grants up to $500 to any employee of a mental health outpatient clinic, mental health center, state commission or division of mental health in any of the 15 states supporting the SREB's mental health program. For further information and application, write the Southern Regional Education Board, 130 Sixth Street, N. W., Atlanta 13, Ga. There is no deadline for applications.

The National Institute of Mental Health of the United States Public Health Service has awarded a grant of $1,740,000 to the University of Nebraska to finance the nation's first clinical-research center for mental retardation. The center will be located at Nebraska Psychiatric Institute in Omaha. Cecil L. Wittson, M.D., director of the institute and head of the university's department of neurology and psychiatry, said the center will seek to better understand the cause of mental retardation, and to develop and refine preventive, diagnostic, and treatment procedures.

The Interstate Postgraduate Medical Association of North America announces that its annual assembly will be held in Cleveland on November 13-16. The Assembly will be co-sponsored by the Ohio Academy of General Practice and will be acceptable for a maximum of 25 hours of category II credit by the AAGP. The program will include scientific presentations and color television provided through the cooperation of the Cleveland Clinic staff and Smith, Kline and French.

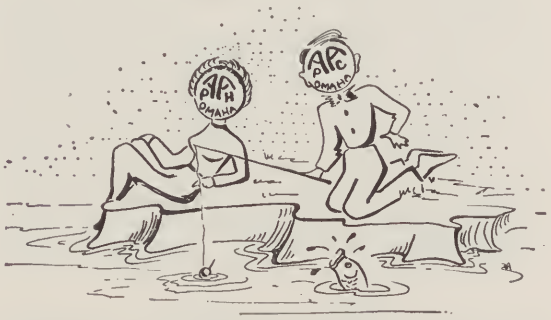
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Maternal Mortality Page

(Continued from Page 710)

a largc amount of bloody serous drainage from the incisional site.

At autopsy, the abdomen was distended, and when the recent surgical incision was reopened it was found to be heavily infiltrated with unclotted blood. After opening the peritoneal cavity, the prosector found approximately 2500 cc of unclotted and partially clotted extravasated blood. Both broad ligament areas were also heavily infiltrated with hemorrhagic extravasation. The serous surface seemed intact. Upon closer dissection of the peritoneal cavity it was not possible to identify a definitive vascular source for this hemorrhage. All of the peritoneal surfaces, both visceral and parietal, were covered with a sanguinous exudate which also involved the otherwise normal post-gestational uterus. The gastrointestinal tract was uninvolved. There was no free blood in the endometrial cavity.

The final anatomical diagnosis was intraperitoneal hemorrhage with terminal acute myocardial decompensation. The final clinical diagnoses included cervical stenosis, term pregnancy, unsuccessful trial of labor, low cervical cesarean section.

Comments:

This was a direct obstetrical death with preventable factors associated with cesarean section. Since the patient was young and of low parity, artificial amniotomy and pitocin stimulation might have been cmployed after the onset of true labor contractions. Failure of progress under these circumstances might have necessitated cesarean section, but on the indication of failed induction of labor rather than questionable primary inertia.

Unexplained shock in a recent postoperative patient should always be investigated to rule out concealed intra-abdominal hemorrhage. This may be done safely under local anesthesia if necessary. In this case, earlier diagnosis of internal hemorrhage might have been life-saving.

In the Books

(Continued from Page 708)

is narrated with medical accuracy and the timing of a good novel. As it becomes evident that the aphasis and hemiplegia are not transitory we begin a series of physical and mental hurdles.

The intcrpersonal relationships of patient with physicians, physio-therapists, speech therapists, family, employer, and friends are informatively stated. One of the speech therapists instructed the patient to keep a diary from which the book was taken. Mr. Ritchie learned to write with his left hand and painfully learned to walk with the aid of a foot brace. The latter is termed a caliper by the British. There are sufficient instances of British speech, customs and patient care to maintain reader interest.

Particularly good was the description of the patient's hostility and fear in the interviews with the speech therapist beginning about six months after the stroke. He was unable to speak a sentence when temporarily retired by his company at this time. Perseverance of the patient, numerous members of a Medical Rehabilitation Centre, and especially his wife, converted a potentially dumb invalid to a rational, intelligent person largely self-sufficient and confident.

His story has a message for patients who have stroke with aphasia. All medical and para-medical personnel, and anyonc who may have friends or relatives with aphasic stroke can gain valuablc insight from this book. Mild stroke patients however could become unnecessarily discouraged by reading this book without interpretation.

A short chapter deals with practical hints for the hemiplegic patient.

Carroll H. Robie, M.D.

KSMA Lists New Members

The following is a list of new members of the KSMA since the last report in thc Junc issue of The Journal:

William Bond, M.D., Ashland
Wallace King, M.D., Ashland
John Koepke, M.D., Lexington
Eugene Slusher, M.D., Ashland

Lynch Hospital Closes

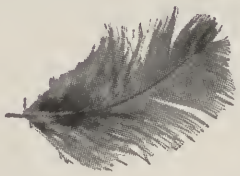
The only hospital in the mining community of Lynch is to close July 1, sister Mary Rosilda, administrator of the Sisters of Notre Dame institution said. According to press reports, two factors forced its closing. Industry moving out of the community has caused a population drop from 10,000 to about 4,000 and the hospital has been losing money for several years.

Health Careers Booklet Published

A booklet entitled "Health Careers in the Blue Grass" has been published by the Greater Lexington Health Careers Committee under the sponsorship of the Lexington Hospital Council. Designed to help those interested in Health Careers, the booklet says at least 140 opportunities are available in the Blue Grass. Various careers are listed and information is given in outline form: what you will do, what education or training you will need, what your opportunities in the Blue Grass are, where you can get more information, and who is eligible.

A postgraduate course in Laryngology and Bronchoesophagology under the direction of Paul H. Holinger, M.D., will be conducted by the Department of Otolaryngology, University of Illinois College of Medicine. Registration will be limited to 15 physicians who will receive instruction by means of animal demonstrations and practice in bronchoscopy and esophagoscopy, diagnostic and surgical clinics, as well as didactic lectures. For further information, write directly to the Department of Otolaryngology, University of Illinois, College of Medicine, 1853 West Polk Street, Chicago 12, Illinois.

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PUBLIC HEALTH PAGE

Volume Drug Market and Possible Dangers*

Russell E. Teague, M.D., M.P.H.

Commissioner of Health
Commonwealth of Kentucky

THE prescription pattern has changed to a large degree, both quantitatively and qualitatively during recent years. There has been a rise in the number of prescriptions filled from 182 million in 1939 to 655 million in 1958, to 712 million in 1959, practically a fourfold increase in 20 years. Furthermore, whereas in 1939, 80 per cent of prescriptions were compounded by the druggist on the premises, at least 90 per cent are now prefabricated by pharmaceutical houses. Mindel C. Sheps, M.D., M.P.H., has just recently submitted an excellent report and analysis of the huge proliferation of drugs currently on the market and the related problem of testing these products for the protection of the public.

Most of the prescriptions are for new drugs, more than 70 per cent of the dollars spent being for products which are less than ten years old. These new products gain acceptance more rapidly and at the same time become obsolete more rapidly. Popularity for a new product is generally attained within a short period of time or else it is doomed to mediocrity through the failure of the promotional program. A parallel to this rapid rise of popularity can be found in the rate of obsolescence in the new drugs. Their life expectancy has been reduced to from two to five years, or about half of what it was ten years ago.

Recognition of the pharamceutical industry's contribution to scientific progress through the provision of many useful drugs does not deny the fact that the production and marketing of these products evolves in the same atmosphere which produces rapid turnovers in the styles and models of automobiles and women's clothing. In spite of some exceptions, the premature and excessive promotion of drugs, and the lack of adequate investigation, makes needless and confusing duplications very common. It would be difficult to estimate how much of the responsibility for the failure of the clinical investigation of effectiveness to conform to accepted scientific standards should be attributed to the present state of the drug market.

In this context, organized efforts for providing objective information concerning the newer drugs on behalf of physicians and their patients are invaluable. It is unfortunate that a great deal of these efforts at the present time must consist of warnings of the undesirability of prefabricated mixtures, of the unproven value of a given drug, of the fact that no advantages over its congeners have been established, or of the uncertainty of its complications. Some of the medical journals' efforts to closely scrutinize advertising material which is submitted to them, the strengthening of the Food and Drug Administration, and recent adverse publicity concerning marketing practices will undoubtedly aid in the control of some of the worst abuses. These efforts are important but fall short of effective protection.

The efforts of medical scientists toward positive measures to improve clinical investigation standards will possible lead, in the near future, to the application of improved methods, for clinical evaluation, to the availability of a larger group of qualified investigators and to a more critical medical profession.

However, it is doubtful whether these efforts alone will be successful in reversing the process that has been described. To suggest that governmental or educational groups be assigned to perform clinical evaluations of all new drugs that are produced does not seem to be either practical or desirable. Such a program would require extensive facilities, an adequate number of trained investigators and an aggregation of patients. Moreover, it would be difficult to justify such a program for the clinical evaluation of all drugs produced, including those whose production is largely motivated by the hope of capturing a portion of someone else's market. Over and above the financial and ethical objections to such a program, competent scientists would be unwilling to make a career of the unrewarding task of performing comparisons of drugs with similar effects.

Mindel C. Sheps, M.D., Associate Research Professor, School of Medicine, University of Pittsburgh has set forth requirements which would seem essential to a rational, scientific and ethical nation-wide pro-

(Continued on Page 715)

**This article was prepared by Strawn W. Taylor, Director, Bureau of Statistics and Records, Kentucky State Department of Health, Frankfort, Kentucky*

Public Health Page

(Continued from Page 714)

gram for the clinical evaluation of drugs in patients and the subsequent use in practice: "that the development, production, and trial of new drugs be governed primarily by medical need and scientifically established criteria." It appears evident that marketing standards, sales and profits are not desirable qualifications for providing the best therapy for sick people. Many of the chemical problems involved in new drug production have been solved. A system for guiding that production through the application of scientific medical methods must be found if the maximum human benefits are to be provided.

Evidence of the value of drugs must be subjected to the rigorous criteria applied to other scientific problems before important progress may be made in this direction. The general adoption of such scientific standards will depend upon individual physicians who prescribe drugs as well as on the organized efforts of hospital staffs and of medical care programs. Convincing evidence in favor of a new drug must be demanded by hospital staffs and by individual physicians before they will accept it. A widespread use of critical standards by which to provide evidence of the clinical value of new drugs can result not only in financial savings but also in appreciable and beneficial improvement in medical care standards for the American people.

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Practical Application of Pancreatic Function Tests

(Continued from Page 660)

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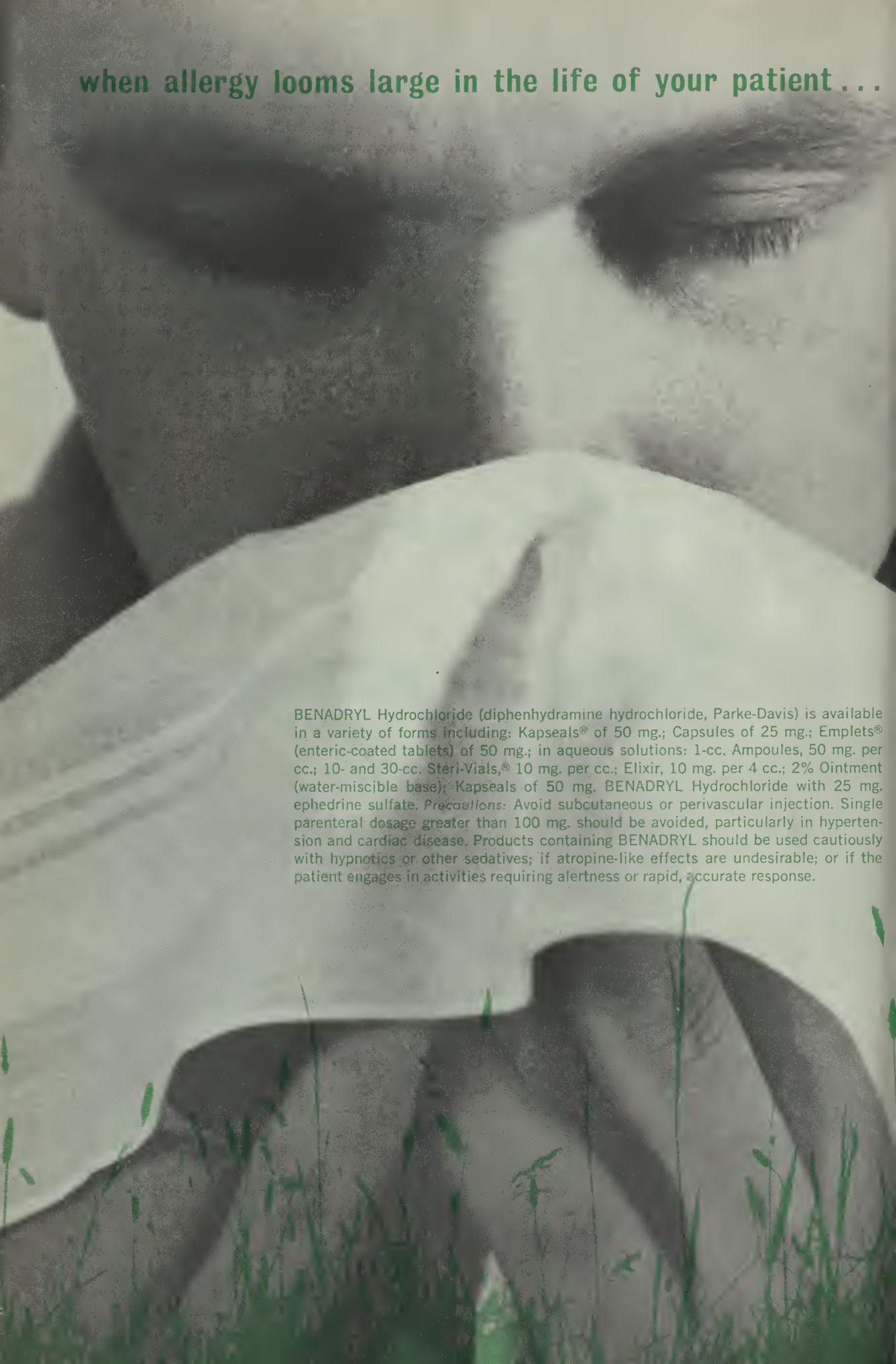
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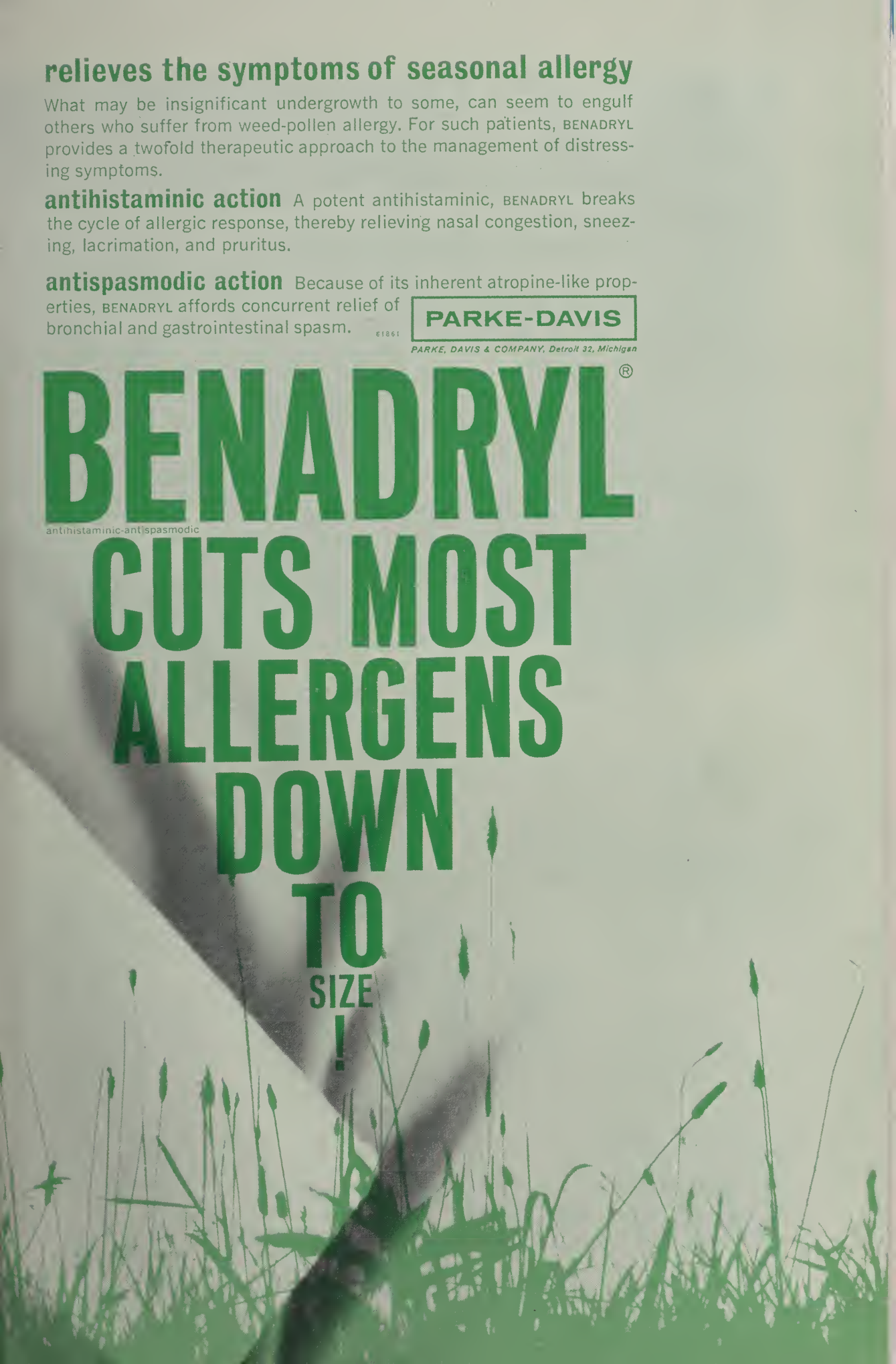
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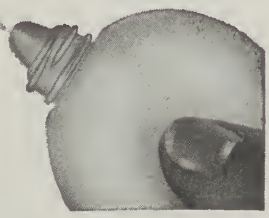
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MESSAGE FROM THE PRESIDENT

THE Annual Meeting of the Kentucky State Medical Association will be held September 19 through 22 at the Columbia Auditorium in Louisville, Kentucky. This meeting is the highlight of our Association's year and an excellent and varied scientific program has been planned. There will also be a number of interesting scientific exhibits as well as many commercial exhibits where you can get the latest information on drugs and instruments. I hope that I shall see each of you there.

I also want to invite you to another part of the meeting which is as important as the scientific program. These are the meetings of the House of Delegates on the nights of September 18 and 20 and of the Reference Committees on the afternoon of September 19. I have often heard it said that KSMA is undemocratic, that many of its decisions are arbitrary and against the wishes of its members and that there is nothing a member can do to get action on a matter in which he is interested. This simply is *not* true.

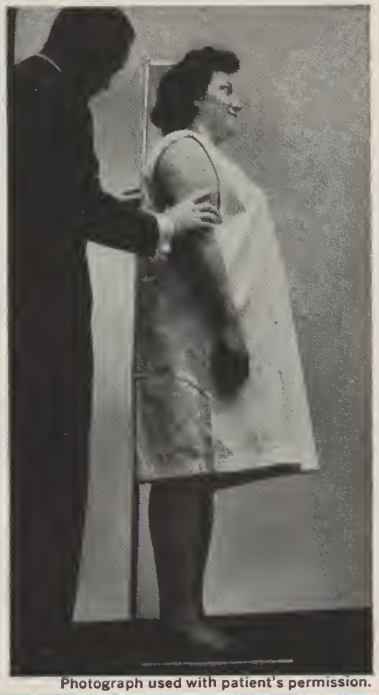
At the first meeting of the House of Delegates, resolutions and reports are presented by the Board of Trustees, the many committees of KSMA, county medical societies or individual members for the consideration of the House. On the next afternoon the Reference Committees meet and consider these different matters. This is the place that each of you can come and voice your approval or disapproval of any of the matters under consideration. The actions of the Reference Committees are in a large degree governed by the opinions expressed at these hearings.

On the next night the House of Delegates, your elected representatives from your own county medical societies, vote on the recommendations of the Reference Committees. Those which are approved are then the policy and bases of action of KSMA. This I feel is truly representative government. If you will attend these meetings you will never again feel that you belong to an undemocratic organization.

See you all in Louisville at the Annual Meeting.

Richard E. Elliott

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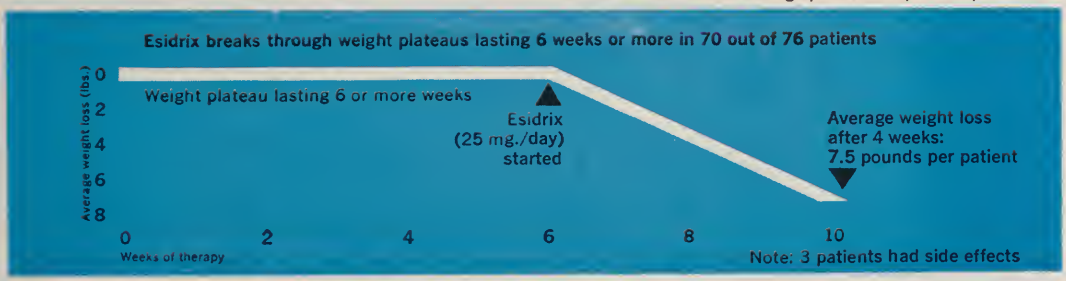


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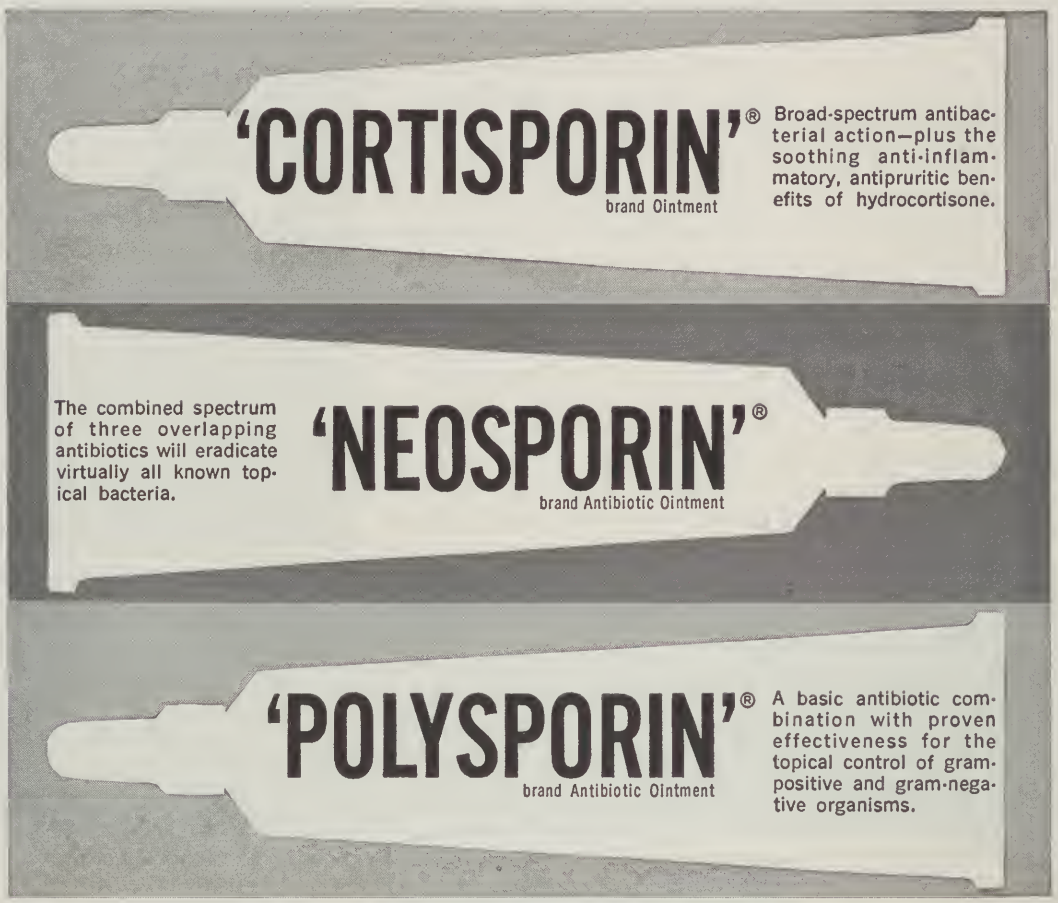
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Reference: 1. Scal, J. C.: Eye Ear Nose & Throat Month. **38**:738 (Sept.) 1959.

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THE INSURANCE PAGE



A Word To Doctors—From A Doctor

ROBERT L. SCHAEFFER, M.D. chief of staff of the Allentown Hospital recently editorialized on the importance of Blue Cross-Blue Shield, and we pass on some of his observations.

Blue Cross and Blue Shield plans, formed by hospitals and doctors, believe that health care financing, organized as a community service and not for profit, is in the best interest of subscribers, doctors, hospitals and the general public.

The goal of these plans is *service,* rather than profit. The concern is *protection,* rather than cost. "Should Blue Cross and Blue Shield ever fail, in my opinion, there will be Government control of medicine," says Dr. Schaeffer.

Hospitals and the doctors can prevent failure of the Plans by curtailing the costs of hospital and medical care by adhering to the following Don'ts.

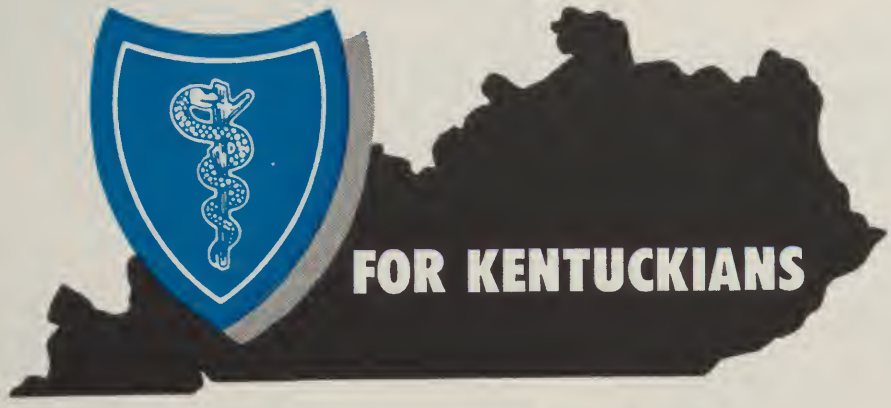
1. DON'T put a patient in a hospital bed just because he wants to be there or because it is more convenient for the doctor to have him there.
2. DON'T order expensive services that are not really needed just because the patient thinks he needs them and they won't do any harm—and, besides, he is covered by insurance.
3. DON'T order a patient admitted on Saturday when nothing is going to be done for him until the doctor visits him Monday. In this respect, pre-admission laboratory testing would be very helpful.
4. DON'T have a patient put in a hospital bed purely for diagnostic purposes that can be accomplished as easily or better in the outpatient department or the office of a specialist.
5. DON'T hold up a patient's discharge because of his family's convenience or for some other relatively unimportant reason.

There are pressures from patients, and it requires a strong professional conscience on the part of the physician to resist these pressures.

Hospital administrators must rely on the doctor to forestall unreasonable demands. Explain to the patient that he is acting against his own self-interest by raising today's hospital costs even higher.

By taking up a hospital bed unnecessarily he may prevent the admission of someone who is critically ill, and some day the tables might be turned on him; and, that by calling upon a hospital for unnecessary service, he is really asking someone else to shoulder his bills, since hospital and insurance rates are based on overall expenditures.

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WASHINGTON NEWS DIGEST



Washington, D. C.—The American Medical Association opposed three major provisions of a bill (S. 1552) that would greatly increase the powers of the federal government in regulation of the ethical drug industry.

These three provisions would turn over to the Department of Health, Education and Welfare and the Food and Drug Administration the responsibility for (1) relaying of drug information to physicians, (2) selecting the names of new drugs, and (3) deciding whether a drug is of value in treating human ills.

The AMA didn't take a position on the bill as a whole because certain of its provisions, "such as the Sherman Act and patent law amendments, are outside our area of competence."

Hugh H. Hussey, Jr., M.D. Chairman of the AMA'S Board of Trustees and Dean of Georgetown University (Washington, D. C.) School of Medicine, was the chief AMA witness at the opening of hearings on the legislation before the Senate Antitrust and Monopoly Subcommittee headed by Sen. Estes Kefauver (D., Tenn.). Dr. Hussey was accompanied by Ernest B. Howard, M.D., Assistant Executive Vice President of AMA, and C. Joseph Stetler, AMA's General Counsel.

With Congress trying for adjournment by about Sept. 1 and much "must" legislation still to be acted upon, it appeared highly unlikely that Congress would complete action on the drug legislation this year.

Doctor Hussey reviewed for the subcommittee AMA's 70-year-record of taking the lead in endorsing legislation designed to insure the purity of drugs and food. The AMA carried on intensive legislative efforts in the field and "is generally credited with being one of the major forces that brought the first Pure Food and Drug Act into being" in 1906, Doctor Hussey said.

Doctor Hussey cited these AMA aims that "we, as physicians, are desirous of achieving:

"—We want all physicians to be well-trained and fully informed on all aspects of the practice of medicine.

"—We want this body of knowledge and reservoir of skills to include a high degree of competence in the selection and proper use of drugs.

"—We want a continuing and expanding flow of useful drug products placed at the disposal of these physicians."

Doctor Hussey pointed out that the AMA already conducts an intensive program of informing physicians about new drugs and that this program is now in process of being greatly stepped up.

"The medical profession believes that the education of physicians is the responsibility and prerogative of the profession itself," he said.

Assigning responsibility for selecting names of new drugs to the federal government would merely be duplication of the program of drug nomenclature which has been operated for many years by the AMA and the pharmaceutical industry, Doctor Hussey declared. This program also has recently been refined and improved, and will continue to meet the need for an orderly system for selecting names for new drugs.

In the final analysis, it is the physician and the pharmacist who must know the non-proprietary names of drugs, he said. These two professions now direct this naming process, and "we do not believe the responsibility for designating and revising names should be assigned to a government agency," he said.

Regarding determination of the efficacy of a new drug, Doctor Hussey said:

"We believe that only the physician has the knowledge, ability and responsibility to make a decision as to what drug is best for a particular patient. He should not be deprived of the use of drugs that he believes are medically indicated for his patient by a governmental ruling or decision.

"Physicians seek to treat the medical problems of *individual patients*. A physician does not treat ten cases of hypertension, he treats ten individual patients, each of whom has a medical problem he has diagnosed as hypertension. He may find that the same dosage of the same form of the same drug will be efficacious in each and all of his ten patients.

"Or he may find that one or more of them need different dosages, or different forms of this same drug. He may, indeed, find that one, two or three of them are allergic to the non-active ingredients used in this brand of the drug, and that a different brand, with other non-active ingredients, is the proper answer.

"Thus, in one patient, a specific dosage of a specific drug might be said to be efficacious. While in another, it would be described as totally ineffective.

"A physician can be told many things about a drug, including its chemistry, its mode of action and, to some extent, its toxic properties. But he must judge its efficacy."

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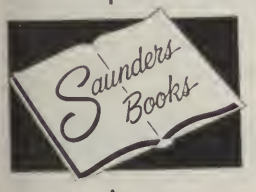
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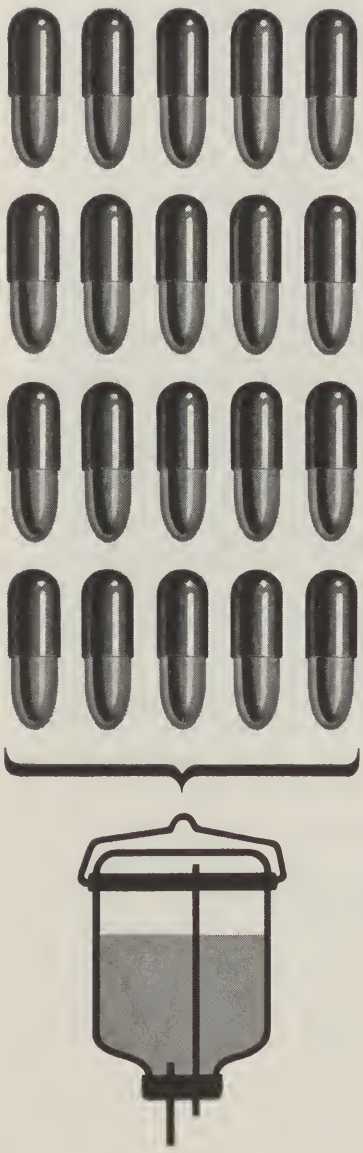
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The Present Status of Vagotomy*

David W. Kinnaird, M.D.

Louisville, Ky.

For the treatment of chronic duodenal ulcers, surgeons may offer any one of three effective operations; vagotomy and emptying procedure, vagotomy plus antrectomy, or sub total gastrectomy.

SEVENTEEN years ago, Dragstedt[1] called attention to the role of the vagus nerves in gastric acid production, and re-emphasized their importance as regards the cephalic phase of gastric secretion. At the same time, he reported the results of section of the vagus nerves in patients with chronic duodenal ulcers. Prior to this report, the surgical procedure of choice in chronic duodenal ulcer was that of the standard subtotal gastric resection, removing approximately two thirds of the distal stomach. Follow-up studies by Dragstedt[2] and others revealed that vagus nerve section did effectively lower the gastric acid secretion, and this was most particularly effective as regards the night secretion of HCl. However, it soon became apparent that the operation was not completely satisfactory because of interference with gastric emptying, occasioned by the resultant atonic stomach. This prompted the addition of an "emptying procedure," such as gastroenterostomy or pyloroplasty, and, with this addition, it was suggested that vagotomy was an effective means of cure for the chronic duodenal ulcer.[3]

In the interval, there have been hundreds and hundreds of laboratory and clinical studies in an attempt to evaluate this operation. Interestingly enough, there has not been uniform acceptance nor, on the other hand rejection, of this concept of surgery of duodenal ulcer. Rather, the surgical world has been divided into two large camps consisting of those who believe that subtotal gastric resection is the operation of choice[4] and those who favor vagotomy with an emptying procedure.[5] More recently, there have been advocates of a combination procedure in which vagotomy is added to a hemigastrectomy (sometimes called antrectomy).[6] Proponents for this "combined" attack claim that it not only interrupts the cephalic (vagal) phase but also eliminates the hormonal (gastric) phase by removal of the antrum. What, then, is the present situation regarding vagotomy? What conclusions can be drawn as to its place in the management of duodenal ulcer patients? For the sake of brevity, in the following discussion the use of the term "vagotomy" implies the simultaneous performance of an "emptying procedure" (either pyloroplasty or gastroenterostomy).

Probably the only available yardstick for

*Presented at the third annual Norton Memorial Infirmary Postgraduate Medical Seminar in Louisville, Kentucky, on December 17, 1960.

evaluating end results in clinical medicine is that of comparison of the various treatment methods—in this case surgical—and their influence upon the patient and the course of his disease. Thus, our conclusions are for the most part based on such an evaluation.

Operation of Choice for Chronic Duodenal Ulcer

Table 1 is an attempt at comparison of the three commonly used operations in the treatment of the intractable chronic duodenal ulcer. The various percentages under each heading are taken from recent surveys of that particular operative procedure from clinics throughout the country. This type of comparative evaluation does not lend itself to scientific statistical scrutiny, but does afford one a rough guide as to end results.

TABLE 1. Results of Surgery of Chronic Duodenal Ulcer

	A (Vagotomy)*	B (Subtotal Gastrectomy)**	C (Vagotomy & Antrectomy)***
	%	%	%
Good Results	76-87	88	82-92
Mortality	.2-2	1-6	1.7-2.8
Recurrence	.5-14	3-5	0.3-1

*References 2, 5, 10, 11, 12 and 13.
**References 3, 4 and 10.
***References 5, 6, 7 and 14.

It appears from this composite picture that the combination of vagotomy and hemi-gastrectomy (antrectomy) yields somewhat better results, less mortality, and a lower rate of recurrence than the other two popular operations. However, in all fairness, the number of these cases[6,7] with long-term follow-up is much less than in the Groups A and B. In addition, the margin of superiority of the "combined" operation over the other two is admittedly narrow. With proven 88% good results in standard partial gastrectomy and similarly 76-87% in vagotomy, these methods should not be abandoned, but rather retained in our surgical armamentarium. Most surgeons will recall certain patients who may not lend themselves readily to a particular operation because of medical contraindications or for simple anatomical reasons. In some poor-risk patients, the quicker, simpler operation of vagotomy might well be a safer course to pursue. At times, the patient with an extremely thick abdomen and a high diaphragm may present a formidable problem to a surgeon who may be forced to depart from his preconceived operation of vagotomy. Certainly, subtotal gastrectomy with removal of two thirds of the stomach might be the choice in the hands of a surgeon who has had no prior experience with vagotomy.

Consideration also should be given to the type of profession or employment that the patient engages in. It has been our observation that a laborer, who requires three full meals daily to meet the needs of heavy energy loss, does better after vagotomy with his stomach intact. In this individual, multiple small feedings required by the gastrectomized patients would be difficult to obtain, while, on the other hand, the office worker may have ready access to canteens for multiple feedings. It should also be stressed that approximately 8% of the patients in Group C, presumably the operation of choice, fail to make the Good Result classification. In short, there is no one perfect operation for all duodenal ulcer patients, but rather there are available three operations with fairly good results of 75% or better. It would seem wise to select the operation on the basis of anatomical and clinical considerations, rather than fitting each patient to a specific operation. Preference for the "combined" procedure should be exercised when the above variables are not thought to be of significance.

Emergency Operations for Massive Bleeding from Duodenal Ulcer

What is the status of vagotomy in surgery of the massively bleeding duodenal ulcer? In the past, the operation of choice for the massive bleeder has been that of standard subtotal gastrectomy with complete diversion of the gastric contents from the ulcer area and usually with excision of the ulcer or control by suture of the bleeding vessel. Recently, however, there has been a trend to the employment of vagotomy for such cases.[8,9] These reports suggest excision of the ulcer or control of bleeding vessels, if technically feasible, while performing a pyloroplasty. The rationale for this approach lies in the fact that the standard subtotal gastrectomy is a more difficult and more pro-

longed operation in the seriously ill patient. The additional operating time and trauma could conceivably increase the already significant risk to the patient. However, it is too early to evaluate vagotomy in the treatment of the massively bleeding ulcer patient. It may well be that this will prove to be the operation of choice, but, for the present, it should be reserved for the elderly poor-risk patient undergoing emergency surgery for bleeding.

Operations for Recurrent Ulcers or Marginal Ulcers

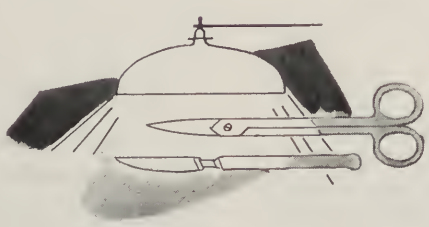
As if to reinforce our belief that there is more than one good operation for duodenal ulcer, it is significant that vagotomy is the treatment of choice in the marginal ulcer that follows partial gastrectomy, and partial gastrectomy is the operation of choice in recurrent ulcer after vagotomy. Thus far, there have been more reported marginal ulcers following standard subtotal gastrectomy because this operation, of course, has been in vogue for many years. Therefore, vagotomy has been popularized as a means of treatment of marginal ulcer. Vagotomy can be performed either through the chest or through the abdomen in this type of situation. It is most surgeons' belief that the abdominal route is better because it permits thorough abdominal exploration as well as evaluation of local changes in the region of the ulcer.

Summary

It now appears that vagotomy is well established as an effective surgical tool in the treatment of the chronic ulcer which resists medical cure. A comparison of the more recent reports in the literature tends to favor the combination of vagotomy plus hemigastrectomy (or antrectomy) as the operation of choice. However, the margin of superiority of this procedure over the older established standard subtotal gastrectomy or vagotomy is a narrow one. It is now evident that all three of these operative procedures are effective in curing a significant percentage of chronic ulcer cases. Decision for or against one of these procedures should be based on the consideration of all aspects of the individual case. This means, simply, the operation should be fitted to the patient and not the reverse. There is some evidence to suggest that vagotomy or vagotomy plus hemi-gastrectomy may be an improvement over the standard subtotal gastrectomy in poor risk massive bleeding ulcer patients. The more common marginal ulcers that have followed standard subtotal gastrectomy over the years can be treated effectively by vagotomy, employing either the thoracic or abdominal route.

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Medical Abdominal Crises*

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Accurate differential diagnosis is often difficult in the critically ill patient with largely abdominal signs. Satisfactory management of systemic disease mimicking the acute abdomen requires precise diagnosis.

PRECISE diagnosis in evaluating the patient with an abdominal crisis in the absence of localizing signs presents a true challenge to the physician. Etiologic considerations are legion and include many localized extraabdominal conditions as well as numerous systemic diseases and syndromes. The importance of differentiation of those crises requiring surgical correction from those requiring specific therapy is obvious. The additional stress of abdominal exploration during many systemic illnesses is extremely hazardous and, in some instances, may prove fatal. Urgent complaints referable to the abdomen may appear during the natural course of innumerable illnesses, but here the etiology has often already been established or soon will appear during continued observation. Accurate evaluation becomes more difficult in the critically ill patient who presents predominantly abdominal symptoms. Some of the more common conditions which may appear in this fashion are tabulated.

Medical Etiologies of Abdominal Crisis

I. Intrathoracic Conditions
   1. Lobar Pneumonia
   2. Myocardial Infarction
   3. Pericarditis
   4. Pulmonary Embolism and Infarction
   5. Cardiospasm

II. Intraabdominal Inflammatory Disease
   1. Acute Hemorrhagic Pancreatitis
   2. Regional Ileitis
   3. Ulcerative Colitis

III. Infections
   1. Systemic Infections
      a. Septicemia
      b. Typhoid Fever
      c. Infectious Mononucleosis
      d. Malaria (Falciparum)
   2. Intraabdominal Infections
      a. Bacillary Dysentery
      b. Tuberculosis
      c. Acute Viral Hepatitis
      d. Amebiasis
      e. Acute Pseudomembraneous Enterocolitis

IV. Metabolic and Endocrine
   1. Acidosis
      a. Diabetes Mellitus
      b. Uremia
   2. Porphyria
   3. Carcinoid Syndrome
   4. Sickle Cell Crisis
   5. Adrenal Cortical Insufficiency
   6. Rheumatic Fever

V. Intoxications
   1. Lead Poisoning
   2. Black Widow Spider Bite
   3. Other Poisons

VI. Miscellaneous
   1. Periodic Disease
   2. Anaphylactoid Reactions
   3. Intestinal Angina
   4. CNS Lesions
   5. Psychogenic

*Presented at the third annual Norton Memorial Infirmary Postgraduate Medical Seminar, Louisville, Ky., December 17, 1960.

Lower Thorax Disease

Because they arise in an area which is neurologically inseparable from the upper abdomen, diseases in the lower thorax are notorious imitators of upper abdominal emergencies. The pain of diaphragmatic pleuritis may produce intense spasm of the abdominal muscles to the extent seen with a perforated viscus. Lobar pneumonia may present with these symptoms prior to the appearance of definite physical or x-ray signs within the chest. However, pain referred from the chest is usually associated with some change in the regularity of respiration and there is relaxation of the abdominal musculature during inspiration. The substernal pain of myocardial infarction is often referred to the epigastrium or right upper quadrant and is particularly likely to be referred to these areas if there has been prior duodenal or gallbladder disease. The serum transaminase may be particularly useful under these circumstances if the changes of myocardial injury have not appeared in the electrocardiogram. A hemorrhagic duodenitis may also be responsible for abdominal pain during the course of acute myocardial infarction.[1] There is an increasing number of patients with coronary artery disease and previous myocardial infarction who are receiving long-term anticoagulants. The possibility of retroperitoneal bleeding after seemingly minor trauma must be considered in these patients. Bilateral adrenal hemorrhage with collapse is a much more unusual complication in this group.[2] Significant abdominal pain, nearly always localized to the epigastrium, may be the initial symptom of acute idiopathic pericarditis. However, shock rarely appears, and severe chest pain usually occurs in a few hours, often associated with the characteristic friction rub.[3]

Abdominal Organ Disease

Various inflammatory diseases of ill-defined etiology and affecting certain abdominal organs may precipitate an abdominal crisis. The sudden, agonizing upper abdominal pain of acute hemorrhagic pancreatitis quickly reaches maximum intensity and is often associated with peripheral vascular collapse. Though a rise in serum amylase may occur with common duct stone, high intestinal obstruction, and perforated or penetrating ulcer, it is nearly always elevated within a few hours after the onset of acute pancreatitis and is a requirement for making this diagnosis. Conservative therapy in relieving pain and inhibiting pancreatic secretory activity is the established management of choice. Regional ileitis may appear abruptly with right lower quadrant pain, fever, tenderness and abdominal rigidity, but, under these circumstances, exploration is warranted to eliminate the possibility of appendicitis. A fulminant form of ulcerative colitis with rapid onset of bloody diarrhea, fever, abdominal pain and tenderness, and tenesmus occasionally occurs. If a specific infectious etiology for these symptoms can be eliminated and there is no response to large doses of corticosteroids, again surgical intervention may be necessary.

Infections, Metabolic and Endocrine Disease

Both systemic and intestinal infections may focus attention on the abdomen of an acutely ill patient because of their association with adynamic ileus. The hypoxia of severe pneumonia may add the picture of ileus to the referred abdominal pain. Specific infections, such as typhoid fever and infectious mononucleosis, may precipitate severe abdominal pain because of their predilection for involving mesenteric nodes.[4] An occasional complication of infectious mononucleosis is spontaneous rupture of the spleen. Bacillary dysentery is suggested by the abrupt onset of fever, abdominal pain, and diarrhea associated with the passage of blood and mucus. Adrenal involvement and circulatory collapse may occur with severe bacteriemias from almost any source but are more often considered in conjunction with extrapulmonary tuberculosis and tuberculous peritonitis. Occasionally, pain in the preicteric phase of acute viral hepatitis may be severe enough to simulate an acute surgical condition. The finding of a markedly elevated serum transaminase (SGOT) may prevent the known hazard of laparotomy in an individual with liver disease.[5]

An increasing number of metabolic and endocrine abnormalities have been described as etiological agents in the precipitation of abdominal crises. Severe abdominal pain, nausea, vomiting, hypotension, and tenderness are fre-

quent symptoms in diabetic acidosis,[6] while an overactive or spastic ileus is frequently associated with uremia. An enlarged liver or acute gastric dilatation may further confuse the abdominal picture of diabetic acidosis. The severe colicky pain of acute intermittent porphyria may mimic intestinal obstruction. There are usually signs of increased peristalsis, absence of leukocytosis, absence of rebound tenderness and muscle spasm, and marked increase of porphobilinogen in the urine which may be measured by the Ehrlich aldehyde test. Marked increase in peristalsis with abdominal pain and diarrhea may accompany the excess circulating serotonin of a functioning carcinoid tumor. Flushing and wheezing usually occur simultaneously with the abdominal symptoms. Acute abdominal pains in the Negro should call to mind the possibility of a sickle cell crisis, particularly if there is pain in the left upper quadrant to suggest splenic infarction. Abdominal pain, nausea, and vomiting are usually seen during an adrenal crisis, but are most often overshadowed by the symptoms of vascular collapse.

Rare and Unusual Diseases

Many more rare and unusual medical conditions may lead to an abdominal crisis. Lead colic is known by the absence of specific characteristics and is largely a diagnosis by exclusion. The biologic poisoning from a black widow spider bite produces rigidity of the abdominal and long muscles of the back. The bite is most often registered on the genitalia, and it would seem logical to expect the average male to recall such a bite in this area. Periodic peritonitis sometimes simulates an acute surgical abdomen,[7] but this entity usually has been confined to peoples of Armenian, Jewish, or Arabic origin. Anaphylaxis may bring on an abdominal crisis of nausea, vomiting, and pain and even hemorrhage from urticaria of the gastric mucosa.[8] However, one can usually expect the concomitant appearance of symptoms in other areas of the body, though these may be relatively confined to the abdomen in Henoch's purpura due to edematous and purpuric lesions of the bowel. Intestinal angina due to atherosclerotic obliteration or narrowing of the ostia of gastrointestinal branches of the abdominal aorta must be diagnosed by exclusion; however, it would be unusual to find pain of another etiology developing at a constant time after eating and not accompanied by physical, x-ray, or laboratory findings.[9] Numerous other entities could be in some manner incriminated in producing abdominal crises, but their rarity would most likely preclude an accurate preoperative diagnosis.

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Male Genital Injuries*

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Injuries to the male genitalia are uncommon, but present certain problems in management. These injuries and their generally accepted treatment are discussed.

WHILE injuries to the male genitalia are uncommon and are not usually associated with the dramatic picture of severe hemorrhage and deep shock such as is seen in injuries to the deep viscera, they present certain problems in management in order to prevent lifelong complications such as strictures, fistula, imperfect erection, infertility and even eunuchoidism. Prevention of these and other complications surely will test the best in every surgeon. The scope of this paper will be limited to a brief discussion of injuries to the penis and skin, injuries of the scrotum and testes, and injuries of the urethra and some of the complications thereof.

Injuries of the Penis

Injuries of the penis are perhaps the most uncommon of this group, and excluding war wounds, acts of sexual perversion, and of the insane, are seen chiefly in heavy industry as a result of exposure to moving machinery. The farmer falling astride of the whirling universal joint on his tractor is an example of one way in which these injuries occur. Lacerations of the penis offer no special problem and bleeding is rarely severe even if the corpora cavernosa are cut unless the injury occurs during erection. In this instance bleeding is quite apt to be profuse and may be exsanguinating. Control of bleeding may be accomplished by a catheter placed about the base of the penis acting as a tourniquet until the wound may be debrided and Buck's fascia closed with catqut sutures. Individual bleeding points in the superficial fascia must be carefully ligated to prevent hematoma formation. Large subcutaneous hematomas should be drained promptly, but small or moderate swelling is best only observed and treated conservatively with ice packs. Since edema is a constant occurrence in trauma, care must be taken particularly in the uncircumcised, to keep the prepuce from retracting behind the corona glandis. The resulting paraphimosis may be the most serious consequence of an otherwise minor injury and must be treated promptly by incising the tightly constricting band and allowing the prepuce to reduce to its normal position.

Conservatism should be the rule in the treatment of severe lacerations and partial amputations, with debridement of only the obviously devitalized tissue and, of course, provision for bladder drainage if there is associated urethral damage. Healing power here is tremendous and the improvement after several days of observation may be astounding.

Vein thrombosis and cavernositis occasionally occur as a result of penile trauma and may be seen after relatively minor injuries such as a simple bruise which may subside spontaneously in a matter of a few days. These are characterized by the persistence of local induration and tenderness of one corpora or the other or perhaps subsequent unequal erections. Treatment is conservative with initial cold compresses to the penis and complete resolution usually occurs after several months.

Treatment of avulsion of the penile skin rep-

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resents a special case in that all available skin remaining at the base of the penis should be spared and debridement here should be lightly done. However, skin remaining at the corona should be completely excised even though it appears to be undamaged. Following this the entire shaft of the penis may be covered with a split thickness graft taken preferably from a non hair bearing area on the body. Should a cuff of skin be left remaining at the distal portion of the penile shaft it will probably remain heavily edematous permanently and be a constant nuisance to the patient. In the event that the patients condition does not warrant definitive treatment of this condition initially, the anterior surface of the scrotum may be split longitudinally and the denuded area of the penis simply buried in the scrotum until such time as definitive therapy can be undertaken.

Injuries of the Testicle

In contrast to penile injuries, injuries of the testicle are of fairly common occurrence. These range in seriousness from the minor small hematoceles which offer no specific therapeutic problem and which will resolve rather quickly after only simple treatment of scrotal elevation and application of ice and a pressure dressing to the scrotum, to the serious injuries seen after gunshot wound and serious automobile wrecks associated with scrotal avulsion.

When marked swelling of the scrotum occurs the patient should be taken promptly to the operating room and the scrotum opened if for no other purpose than to evacuate existing clots and ligate any bleeding vessels which may be found. After incision and drainage of the scrotum the wound may be closed by a continuous mattress suture of fine chromic catgut around a small thyroid type drain which should be left in for from twenty-four to forty-eight hours. Use of catgut for approximation of the scrotal skin obviates the necessity for removal of non-absorbable sutures after healing is complete at which time such material may be deeply imbedded within the folds of the scrotal skin.

In severe injuries to the testicle every effort should be made to preserve the testicle unless its total destruction by maceration and devitalization is obvious. In cases of bi-lateral testicular injury an attempt should be made to spare at least one testicle no matter how badly injured it may appear to be. In all of these cases and especially those where there have been penetrating wounds and/or scrotal avulsions antibiotics should be given along with tetanus toxoid. Postoperative pressure dressings should be routinely used along with ice therapy and elevation of the scrotum. The use of proteolytic enzymes would appear to be indicated also. In scrotal avulsions where the testicular damage does not appear to be severe, treatment consists of light debriment, saline irrigation, replacement of the testicle in its bed and closure of the scrotum around a drain. Should there be inadequate skin remaining, the testes may be transplanted under the skin of the inner aspects of the thighs until a more suitable time for plastic construction of a scrotum.

Injuries of the Urethra

Injuries of the urethra are not at all uncommon and may occur with fractures to the pelvis, the straddle injury, sadistic use of foreign bodies inserted into the urethra or by accidental perforation of the urethra associated with the injudicious use of metal catheters and sounds. Rupture of the urethra may also occur as a result of inflammatory strictures with periurethral abscess formation and subsequent fistulization. There are several important do's and don'ts concerning the treatment of ruptured urethra that should be discussed.

Probably the most important step in treatment of this condition is early diversion of the urinary stream. This should be done before extravasation of urine occurs if the rupture lies distal to the triangular ligament. Of course, in rupture of the membranous urethra or rupture of the bladder, extravasation is immediate. However, in rupture of the distal urethra extravasation of urine must await the first voiding post-injury. In a patient in whom laceration is suspected, such as the man who describes a straddle fall and who shows a little oozing of blood from his meatus, evaluation of the extent of his injury may be determined by the simple expedient of passing a Foley catheter into the bladder. If urethral continuity is preserved the catheter should pass readily into the bladder where the bag can be inflated and the catheter left indwelling for several days to allow the injured area a chance to seal over. Should obstruction be met in passage of the

catheter, the diagnosis of separation of the urethra is made. In this case a suprapubic cystotomy should be done and secondly an attempt at anastomosis of the urethral canal be made. Where rupture of the membranous urethra or bladder is suspected I prefer the suprapubic method with exploration of the retropubic space and direct anastomosis of the membranous urethra over an indwelling urethral catheter. A suprapubic tube may be left in place here for several days in order to assure adequate drainage and prevention of obstruction of the urethral catheter by clots. The urethral catheter must remain until healing is complete.

Should there be evidence of marked extravasation over the anterior abdominal wall, multiple slash incisions and through and through drainage should be made through the entire area. Should the rupture of the urethra occur distal to the membranous urethra and the extravasation be limited to the scrotum, this area should be thoroughly drained using multiple through and through drains.

Healing of the bladder and urethra is usually gratifying but unless approximation of the urethra is accurate a stricture of the affected area of the urethra may be expected after healing is complete. These patients therefore should all be observed for several months post-operatively with periodic gentle dilatation of the urethra to determine the presence, degree of severity, and location of any strictures which may occur.

Summary

In summary, injuries of the genital tract including injuries of the scrotal and penile skin, injuries of the penis, urethra and testes have been discussed briefly along with the generally accepted treatment of these.

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Manuscripts should be submitted in duplicate to The Journal of KSMA, an original copy and one carbon, and typed with double spacing. Maximum length of an article should not exceed 4500 words; the Board of Consultants on Scientific Articles prefers that they be briefer than this when possible.

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Please mail your scientific articles to The Journal of the Kentucky State Medical Association, 1169 Eastern Parkway, Louisville 17, Kentucky.

Griseofulvin In Superficial Mycoses*

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The method of action of griseofulvin is discussed with an outline of therapy for treating the superficial mycoses. Griseofulvin is a safe and efficient drug; relapses are relatively few and complications are mild.

Historical

OXFORD, et al., isolated Griseofulvin from Penicillium griseofulvin in 1939 and the antibiotic was then used for the treatment of plant mycoses. In spite of this drug being employed in fungus infections in plants, it was not until 1958 and 1959 that Gentles employed it by mouth in treating tinea in guinea pigs. He was able to recover the drug in the hair. The first to employ it in human beings was Riehl of Vienna (1958). This was soon followed by Harvey Blank in this country. Since then, numerous articles have been published testifying to its efficacy in treating many of the superficial fungus infections of the skin, hair, and nails. Griseofulvin-resistant strains of fungi has been reported but apparently such cases are relatively infrequently encountered.

Method of Action

Heretofore, the stumbling block in curing fungus infections of the nails and hair was to get the drug to penetrate the keratin. Griseofulvin, taken internally, has this ability. It is fungistatic and not fungicidal. Its action is to inhibit and prevent further reproduction of organisms, and thus as the infected skin, nail, or hair is shed or extruded, the new tissue grows in uninfected. Thus, one can readily understand why it may require from four to twelve months to cure some of the mycotic infections of the nails.

Indications

Trichophytons and microsporons respond favorably to Griseofulvin but with the exception of sporotrichosis the deeper-seated fungus infections such as blastomycosis and actinomycosis do not respond to this drug. Tinea versicolor likewise is resistant to Griseofulvin, as is moniliasis which is frequently made worse by its use. From a practical standpoint, however, it can be said that most superficial fungus infections of the skin and its appendages can be cured with the judicious and long use of Griseofulvin in adequate dosage. It is most important, therefore, to establish the accuracy of your diagnosis before commencing therapy.

Dosage and Duration of Therapy

Dosage. The optimum dosage of Griseofulvin has not yet been determined. The following has proven satisfactory in our experience:

Children.—Dosage of 20-25 mg. per kilogram of body weight. This, from a practical point of view, is essentially as follows:

30 - 50 lbs. —250 to 500 mg. daily
50 - 75 lbs. —500 to 750 mg. daily
75 -100 lbs. —750 mg. daily
Over 100 lbs. —As an adult. One gm. in divided doses of 250 mg. q.i.d.

Occasionally it may be necessary to emulsify the tables in chocolate syrup or its equivalent for some of the younger children.

Adults.—One gm. in divided doses (250 mg. q.i.d. or 500 mg. b.i.d.).

*Presented at the third annual Norton Memorial Infirmary Postgraduate Medical Seminar in Louisville, Kentucky, on December 17, 1960.

Duration. In our experience, we have found the following schedule produces satisfactory cures, negligible complications, and very few relapses:

Tinea Pedis ("Athletes Foot").—Three to six weeks. In the vesicular type or those due to t. rubrum, it is frequently necessary to extend therapy a few weeks longer.

Tinea Corporis and Tinea Cruris.—Two to four weeks. If the infection is due to t. rubrum, eight weeks or even longer therapy may be required.

Tinea Capitis.—Three to six weeks. Recently Friedman and others have reported splendid results with single massive doses of Griseofulvin (3-5 gm.) in cases due to Microsporon audouini.

Favus infections of the scalp also respond to Griseofulvin, but very few cases of its use have been reported because of the rarity of this infection. It is endemic in Eastern Kentucky and we are at present treating a series of cases with this drug. In the not too distant future, a clinical report should be forthcoming.

Tinea Barbae.—Two to four weeks.

Onychomycosis.—Fingernails — Four to six months.

Toenails — Six to twelve months plus.

We have treated one case in which the fingernails cleared in six months, and after thirteen months of therapy there is still slight involvement of the toenails.

Sporotrichosis.—Four to six weeks. This may have to be revised, for too few cases have been treated to date with this drug.

In many of the superficial infections, clinical cures seem evident in two weeks with occasional marked symptomatic relief in three to five days. We advise the patient to take the drug an additional two weeks to prevent any relapse.

Contraindications

To our knowledge there are none. We originally insisted upon CBC's for patients under therapy, but we now feel that this is no longer necessary.

Reactions

Headaches, gastrointestinal symptoms, including nausea, heartburn, flatulence and diarrhea have been reported, as well as urticaria and occasional lethargy, fatigue, and dry mouth. Rarely are these sufficiently severe to cause discontinuance of therapy. We have had one patient, however, for whom it was necessary to stop the drug because of severe headache; and another because of extensive urticaria.

Summary and Conclusions

1. Griseofulvin is a safe and efficient drug for treating many of the superficial mycotic infections of the skin and its appendages.

2. Relapses are relatively few and complications mild.

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CASE DISCUSSIONS
From The
University of Louisville Hospitals



Subacute Perforation of Gallbladder with Subhepatic Abscess Simulating Carcinoma of the Gastric Antrum In a Patient with Pernicious Anemia †

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and Malcolm M. Stanley, M.D. ***

Case Presentation

M. C.A. was a 74-year-old white male retired railroad worker who felt well until two weeks prior to admission when he noted the onset of weakness and malaise. Other symptoms consisted of a flushed, feverish feeling with daily afternoon temperature elevations to 101°. There were no chills or night sweats. He felt a tightness in his adomen paticularly in the right upper quadrant and he thought his abdomen had enlarged somewhat during the two weeks prior to admission. There was no history of blood loss from the G. I. tract. He had had "heartburn" for two to three weeks prior to admission. Ten days prior to admission he had been hospitalized elsewhere; he remained four days during which he experienced anorexia and nausea but did not vomit. At the time of admission his appetite had improved. He had had no jaundice. He had noted no change in the color of his urine or stool. His weight had been stable for four years.

Past History

In 1949 a diagnosis of pernicious anemia was established at this hospital. He had typical clinical and laboratory findings including histamine achlorhydria. Following treatment with vitamin B_{12} there was a reticulocyte response to 32 per cent with a good clinical and hematologic response. He had been maintained on monthly injections of vitamin B_{12} and felt well until the present illness. There was no family history of cancer and no previous surgery.

Physical Examination

The temperature, pulse and respiration were normal. Blood pressure was 134/70. Patient was a well developed, well nourished, gray haired white male who was ambulatory. He was alert, well oriented, and cooperative. He appeared somewhat pale. Ophthalmic examination was normal. Mouth: The tongue was red with moderate loss of papillae. Chest and lungs were normal. The heart was normal. The abdomen was slightly distended with slight tenderness in the right upper quadrant. The liver was palpable 6 cm. below the right costal margin. The findings varied with different examiners. All examiners agreed that the liver was enlarged; some believed the surface to be nodular, whereas others regarded it as smooth. No other

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Fig. 1a. Preoperative x-ray of stomach shows the antral filling defect. A duodenal diverticulum is also seen.



Fig. 1b. Postoperatively, the deformity of antrum has disappeared and there is an entirely normal appearance in this area. The duodenal diverticulum is again seen.

organs or masses were palable. There was no evidence of increased collateral circulation. Genitalia: Normal. Rectal examination was normal; feces were soft and yellow; there was no rectal shelf. Neurologic examination was normal.

Laboratory Studies

Admission, 10/20/60: WBC 13,350 neutrophils 44, stabs 1, bands 11, lymphs. 38, monos. 4, eos. 1, myelocytes 1. Hematocrit 32.6%, Hgb. 10.2 gms. /100 ml. Sedimentation rate 58 mm. /hr. (Wintrobe). Urinalysis: Normal except for a trace of albumin. Urine culture: Sterile. Blood urea nitrogen 18 mgm. /100 ml., total serum bilirubin 0.32 mgm. /100 ml. Thymol turbidity 2.8 units; thymol flocculation 3 plus. Total serum proteins 6.1 gm. /100 ml., albumin 2.7, globulin 3.1 gms. /100 ml.; serum alkaline phosphatase 6.5 Bodansky units (normal to 9 Bodansky units). VDRL microflocculation, non-reactive. Prothrombin time 15.9 seconds with control of 12.9 seconds. Bleeding time 3 min., coagulation time 9 min.

10/26/60: WBC 12,500 with slight shift to left. Cephalin flocculation 3 plus in 48 hours. SGOT 21 units.

10/27/60: Serum iron 33 mcg./100 ml., total iron binding capacity 293 mcg./100 ml. Stool examination, one specimen, occult blood positive with hematest.

11/2/60: WBC 6,900, normal differential, hemoglobin 9.2 gms./100 ml. and hematocrit 26.7%.

X-rays: 10/21/60—Chest normal. Upper G. I. series: Report of two examinations done on consecutive days: Esophagus was normal; fundus of stomach was normal, body showed no abnormalities. The distal 6 cm. of the stomach had an abnormal mucosal pattern with lack of distensibility. (Fig. 1a). In this area there was a large filling defect with a sharp shelf-like proximal edge. Emptying of stomach was only slightly impaired, however. Duodenal bulb was normal; a 3 cm. diverticulum was seen in descending duodenum.

11/4/60: Barium enema was normal. EKG was normal. Uropepsinogen excretion was 3 units per hour (normal 14-40).

10/26/60: Needle liver biopsy: (Fig. 2). Sections showed fat vacuoles in the hepatic cells and foci of infiltrations of polymorphonuclear leukocytes, lymphocytes and plasma cells. No neoplastic cells were seen. The inflammation was particularly marked in the region of the bile ducts. Repeat liver biopsy on 11/10/60 revealed considerable decease in the inflammatory infiltrate previously reported. No neoplastic cells were seen.

Progress In Hospital

The patient was afebrile during the first week of his hospital stay except for a slight fever following his initial liver biopsy which subsided spontaneously. Thereafter his oral temperature ranged between 99 and 100°. He ate well and said he felt well.

He was gastroscoped on 10/27/60. The angulus appeared pliable and only a small portion of the proximal antrum was seen and this appeared normal. The mucosa of the body was atrophic. The impression was atrophy of gastric mucosa, severe.



Fig. 2. Photomicrograph of liver tissue (first needle biopsy, preoperatively) (x 430) shows the transition between relatively normal liver (lower left corner) and an inflamed area (beyond upper right corner). This latter actually was a micro-abscess.

At peritoneoscopy on 11/14/60 the omentum was adherent to the liver edge and the anterior peritoneum so that the edge of the right lobe of the liver particularly over the lesser curvature of the stomach and the gallbladder region could not be seen. A small portion of the left lobe of the liver appeared normal. There was no ascitic fluid.

An exploratory laparatomy was performed on 12/2/60; the preoperative diagnoses were pernicious anemia and probable carcinoma of the stomach.

On opening the abdomen the omentum was very adherent to the border of the right lobe of the liver. There was abundant inflammatory reaction in this area. The adhesions were removed from the shelving border of the liver, and it was noted that a gallstone was lying in a small inflammatory mass at the upper border of the gallbladder bed. Further dissection revealed that the gallbladder with the stone had probably perforated and that an abscess had formed in the subhepatic area. The gallbladder was then removed. An operative cholangiogram appeared normal. In summary, the patient was found to have cholecystitis, cholelithiasis, perforation of the gallblatter, and abscess formation extending into the liver. Cholecystectomy, drainage of the abscess, and cholangiography were performed. The stomach was grossly normal both to inspection and palpation.

Microscopic sections were reported as chronic cholecystitis and chronic inflammatory tissue with microabscesses.

The patient's postoperative course was uneventful. Surgical drains were removed in a few days. He was discharged from the hospital on 12/12/60.

He was seen in Surgical follow up clinic on 1/10/61 and was doing well. His weight was stable, and his appetite was good. He was rehospitalized for further follow up study from 3/20-3/30/61. His dict had not been restricted and he had no digestive disturbance. He had continued to receive monthly injections of vitamin B_{12} from his local physician. There was no abdominal tenderness, and the liver was not palpable. On 3/22/61 an upper G. I. series was reported as normal except for the diverticulum on the medial side of the descending duodenum. (Fig. 1b).

A Schilling test was performed on 3/22/61. The patient excreted 1.6% of the orally administered dose of radioactive vitamin B_{12} in his urine. (Normal range above 10%). On 3/29/61 radioactive vitamin B_{12} plus intrinsic factor were given orally and 16.8% was excreted in the urine. These results confirmed the previous diagnosis of pernicious anemia. The patient was discharged to the care of his private physician.

Discussion

Because of the abnormal upper G. I. series suggesting carcinoma of the gastric antrum on two successive daily examinations, our impression was that the patient had pernicious anemia and carcinoma of the gastric antrum.

The incidence of gastric cancer has been reported increased in patients with pernicious anemia in England,[1] Finland,[2] and in this country.[3, 4] The usual estimates are that gastric cancer in patients with pernicious anemia is approximately two to four times as common as in the general population of the same age. Magnus[1] calculated the incidence of gastric cancer in pernicious anemia both as the approximate number of cases per 1,000 patient-years and from the mortality from gastric cancer in these patients compared to that of the general

population of the same age group. There was good agreement between the two methods of calculating the incidence. In many of these patients the malignant lesions were in the antrum. Zamcheck et al[4] summarized their own and other series, representing 174 cases of pernicious anemia with gastric cancer. Eighty-seven of these were in the body and fundus, sixty-nine were in the pylorus or antrum, and twenty-two were too diffuse to be localized. These and similar data influenced us considerably in our preoperative diagnosis of carcinoma of the stomach.

It was considered probable that tumor metastases to the liver were the cause of the abdominal mass and for this reason the initial needle biopsy of the liver was performed. No neoplasm was found; instead, the marked inflammatory reaction was noted in the specimen. We attributed this to reaction to liver metastases which the needle had missed. Hence a second needle biopsy of the liver was performed two weeks later; again no tumor tissue was found. The degree of inflammatory reaction (cholangiolitis and micro-abscess) had decreased considerably. It is possible that the severe involvement was spotty and that the specimen by chance did not include such markedly abnormal tissue. In retrospect, the liver biopsies, both done with the intercostal approach and thus some distance from the subhepatic abscess, should have given a definite clue to the correct diagnosis.

The result of the peritoneoscopic examination was puzzling since it was reported that no abnormality was visualized. However the right lobe of the liver and the gallbladder area can usually be seen without any difficulty at peritoneoscopy. The adherent omentum obscuring this area should have suggested that there was or had been an inflammatory process in this region. The negative gastroscopic examination except for the presence of g a s t r i c atrophy was explained preoperatively as inability to visualize adequately the distal stomach.

In reviewing pseudo-tumors of the gastric antrum Nelson and Salvador reported[5] a patient with untreated pernicious anemia who on upper G. I. series was thought to have an antral carcinoma. After a short period of treatment for pernicious anemia, with no improvement in the radiologic picture, an operation was performed and no tumor was found. However, the mucosa of the antrum was studded with mucus cysts lined by columnar epithelium with overlying atrophic gastric mucosa. On repeat G. I. series after three months of further vitamin B_{12} therapy much of the deformity of the antrum had disappeared. They cited two additional cases reported in 1935 in which the antrum showed a deformity almost diagnostic of carcinoma of the antrum and pylorus. Both patients were treated medically and their abnormalities previously seen by x-ray disappeared. They found no reports of this phenomenon in the literature after 1935 and concluded that pseudo-tumor of the gastric antrum was extremely rare.

Zamcheck et al[4] described one patient as showing a constant irregularity of the antrum on G. I. series which was diagnosed as carcinoma of the antrum. There was no evidence of carinoma at autopsy. Her signs were believed caused by adhesions which followed a hysterectomy done twenty years before. They also recorded a second patient with pernicious anemia whose upper G. I. series showed polypoid filling defect of the distal half of the antrum, diagnosed as cancer. Surgery was refused and four years later there was no further weight loss. The patient still refused surgery. In view of the long lapse of time, the authors discarded the diagnosis of carcinoma. In our opinion they were not justified in this decision on these grounds alone.

Perforation of the gallbladder usually occurs in one of three ways:[6, 7, 8]

1. Free perforation into the abdominal cavity with generalized peritonitis.

2. Subacute perforation with either pericholecystic or subhepatic abscess in the region of the gallbladder.

3. Chronic perforation into adjacent organs, as the duodenum, with fistula formation.

It is generally recognized that subacute perforation with pericholecystic abscess is the most common form of perforation.[6, 7, 8, 9] While most of these patients have had previous symptoms of gallbladder disease, an occasional patient will present with no previous history of gallbladder disease, and only minimal tenderness, fever, and leukocytosis will be present. Fletcher and Ravdin[8] reported that five of their twenty-five cases with subacute perforation had perforated into the liver. This appeared to

be the case in our patient. The mortality in this type of perforation is low and convalescence from operation is usually smooth.

In contrast to the well-known disturbances of gastric function, the occurrence of biliary tract dysfunction in pernicious anemia appears to be less well appreciated. Regarding an association of gallbladder disease with pernicious anemia, the older literature is indefinite. Murphy[10] recorded a 10% incidence of cholelithiasis and cholecystitis in over five hundred patients with pernicious anemia. This was not a systematic study and reflected only the symptomatic cases. He regarded the association as merely coincidental. Wilkinson[11] did not list biliary tract disturbances among those diseases found in 370 cases of pernicious anemia. In 1934 Bethel and Harrington[12] found abnormal gallbladder function by roentgenological criteria in 22.5 per cent of 58 patients. This same year Brown[13] reported finding either cholecystitis or cholelithiasis in 15.9 per cent of 151 autopsies performed on patients with pernicious anemia. Jones and Joyce[14] were more impressed with the occurrence of gallbladder disease and stated that in all of twenty-six cases of pernicious anemia which they personally studied, "chronic infection of the gallbladder has been positively demonstrated."

In recent years biliary tract disease has been found to be a frequent concomitant of pernicious anemia. In a well-studied group of 48 patients, Boyden and Layne[15] found nonvisualization of the gallbladder in 42 per cent of the cases. These authors also reported necropsy studies in 105 cases of pernicious anemia. Analysis of the pathology reports revealed that 32 per cent had either cholelithiasis or cholecystitis or there was surgical absence of the gallbladder.

However, the above view is by no means unanimous. Thus, Zollinger, Britt, and Ellison[16] state that "there is a decreased incidence of gallstones in patients with pernicious anemia." No figures are given to support this assertion, however.

In this case the gastric content was not examined for cancer cells and the gallbladder was not x-rayed. Although negative examinations are not usually conclusive, the failure to find cancer cells in the gastric aspirate plus nonvisualization of the gallbladder would have added evidence to the results of the needle liver biopsies, the negative gastroscopy, and the findings at peritoneoscopy so that the correct diagnosis might have been strongly suspected preoperatively. It was only at operation that the correct diagnosis was finally made.

Although the stomach was not opened at operation, an extrinsic abscess was found which seemed to cause the deformity seen by x-ray. This inflammatory mass appeared to be an adequate and complete explanation for the entire syndrome. The apparent absence of any intrinsic disease as determined by palpation seemed to justify the decision not to biopsy the mucosa. The finding that the deformity of the stomach had disappeared postoperatively was also confirmatory.

Conclusions

1. An unusual case of pernicious anemia with subacute perforation of the gallbladder and abscess in the hilum of the liver simulating carcinoma of the gastric antrum has been described.

2. Serial needle biopsies of the liver by the intercostal approach, performed preoperatively, showed considerable inflammatory involvement of the liver substance. This together with the findings at peritoneoscopy and the negative gastroscopy probably provided enough evidence for a diagnosis preoperatively. X-ray of the gallbladder and cytologic examination of gastric aspirates were not done; these would undoubtedly have added important data which would have led us away from our diagnosis of gastric cancer.

3. From a survey of the literature, there is some disagreement about the incidence of biliary tract disease in patients with pernicious anemia. It seems likely that it is no less frequent than in the general population.

(References on Page 813)

SPECIAL ARTICLES

Report On Actions Of The AMA's House Of Delegates At the 110th Annual Meeting, June 25-30, In New York

KSMA's three delegates, two of the three alternates, its president and president-elect represented the Association at the 110th Annual Meeting of the AMA's House of Delegates in New York City June 25-30.

From KSMA were W. Vinson Pierce, M.D., Covington, Robert C. Long, M.D., Louisville and George Brockman, MD., the new third delegate from Greenville. Alternate George Archer, M.D., Prestonsburg, was not present because of illness. Other alternates in attendance were J. Vernon Pace, M.D., Paducah, and John Quertermous, M.D., Murray, KSMA President Richard G. Elliott, M.D., Lexington, and President-Elect Gaithel Simpson, M.D., Greenville.

Osteopathy, medical discipline, communications, surgical assistants, drug legislation, general practice residencies, relations with allied health professions and services, and poliomyelitis vaccine were among the major subjects covered by 115 resolutions and 28 reports acted upon by the House of Delegates.

The reference committees to which the above resolutions and reports were referred met Tuesday and each was covered by one or more KSMA representatives that had been assigned by our senior delegate. A breakfast caucus of the Kentucky group was held early Wednesday morning, before the second meeting of the House. The delegates were briefed on the discussion of the major items in the reference committees. Doctor Pierce served on the important Insurance and Medical Service Reference Committee which considered 21 reports and 11 resolutions.

Osteopathy

In considering a report of the Judicial Council and three resolutions on the subject of osteopathy, the House of Delegates agreed with the intent of the report and resolutions, but instead adopted the following statement of AMA policy:

"1. There can never be an ethical relationship between a doctor of medicine and a cultist, that is, one who does not practice a system of healing founded on a scientific basis.

"2. There can never be a majority party and a minority party in any science. There cannot be two distinct sciences of medicine or two different, yet equally valid systems of medical practice.

"3. Recognition should be given to the transition presently occurring in osteopathy, which is evidence of an attempt by a significant number of those practicing osteopathic medicine to give their patients scientific medical care. This transition should be encouraged so that the evolutionary process can be expedited.

"4. It is appropriate for the American Medical Association to *reappraise its application of policy* regarding relationships with doctors of osteopathy, in view of the transition of osteopathy into osteopathic medicine, in view of the fact that the colleges of osteopathy have modeled their curricula after medical schools, in view of the almost complete lack of osteopathic literature and the reliance of osteopaths on and use of medical literature, and in view of the fact that many doctors of osteopathy are no longer practicing osteopathy.

"5. Policy should now be applied individually at state level according to the facts as they exist. Heretofore, this policy has been applied collectively at national level. The test now should be: Does the individual doctor of osteopathy pratice osteopathy, or does he in fact practice a method of healing founded on a scientific basis? If he practices osteopathy, he practices a cult system of healing and all voluntary professional associations with him are unethical. If he bases his practice on the same scientific principles as those adhered to by members of the American Medical Association, voluntary professional relationships with him should not be deemed unethical."

Medical Discipline

In a major move designed to strengthen the profession's disciplinary mechanisms, the House approved the conclusions and recommendations of the Medical Disciplinary Committee, with only three word changes. The House discharged the committee with thanks and commendation and directed that its functions be assumed as a continuing activity of the Judicial Council.

One recommendation suggests that "The bylaws of the American Medical Association be changed to confer original jurisdiction on the Association to suspend or revoke the AMA membership of a physician guilty of a violation of the Principles of Medical Ethics or the ethical policy of the American Medical Association regardless of whether action has been taken against him at local level."

Another "encourages and urges that each state association report annually to the American Medical Association all major disciplinary actions taken within

its jurisdiction during the preceding calendar year."

The report urged state and county medical societies to utilize grievance committees as "grand juries" to initiate action against an offender so as to obviate the necessity of making an individual member of a medical society complain against a fellow member.

The House suggested that each medical school develop and present a required course in ethics and socio-economic principles, and that each state board of medical examiners include questions on ethics and proper socio-economic practices in all examinations for license.

The report concluded with a recommendation that "American medicine at the national, state and local level maintain an active, aggressive and continuing interest in medical disciplinary matters so that, by a demonstration of good faith, medicine will be permitted to continue to discipline its own members when necessary."

Communications

Acting upon four resolutions related to the Association's public relations program, the House adopted a substitute resolution directing the Speaker of the House of Delegates to name seven elected members of the House as a special committee "to study and continually advise the Board of Trustees on the broad planning and coordination of all phases of communications of the American Medical Association, so that the public and the members of the medical profession are properly and adequately advised of the policies and concern of the medical profession with respect to all phases and aspects of medical care for all people."

The House agreed with a reference committee opinion that "we have a very adequate Division within the AMA capable of implementing any program of communications." The approved committee report also said that "the Communications Division of the AMA needs the active support and cooperation of the House and of all members of the Association."

Surgical Assistants

In considering a Board report and two resolutions on the subject of surgical assistant's fees, the House approved the following five basic principles developed by the Judicial Council and the Council on Medical Service:

"1. Each member of the AMA is expected to observe the Principles of Medical Ethics in every aspect of his professional practice.

"2. Each doctor engaged in the care of the patient is entitled to compensation commensurate with the value of the services he has personally rendered.

"3. No doctor should bill or be paid for a service which he does not perform; mere referral does not constitute a professional service for which a professional charge should be made or for which a fee may be ethically paid or received.

"4. It is ethically permissible for a surgeon to employ other physicians to assist him in the performance of a surgical procedure and to pay a reasonable amount for such assistance.

"This principle applies whether or not an assisting physician is the referring doctor and whether he is on a per-case or full-time basis. The controlling factor is the status of the assisting physician. If the practice is a subterfuge to split fees or to divide an insurance benefit, or if the physician is not actually employed and used as a bona fide assistant, then the practice is contrary to ethical principles.

"5. Under all other circumstances where services are rendered by more than one physician, each physician should submit his own bill to the patient and be compensated separately."

Efficacy of Drugs

The House strongly endorsed a Board report which pointed out the problems that would result from amending the Food, Drug and Cosmetic Act to authorize the Food and Drug Administration to determine the efficacy, as well as the safety, of a prescription drug prior to the approval of a new drug application. The AMA will oppose such legislation before the Kefauver Committee, the report pointed out, on the basis that "a decision with respect to the effectiveness of drugs is dependent upon extended research, experimentation and usage." The House agreed that vesting such authority in the Food and Drug Administration would operate to limit research, the marketing of drugs and the exercise of discretion by the medical profession. "The marketing of a relatively useless drug is infinitely less serious than would be the arbitrary exclusion from the market of a drug that might have been life saving for many persons," the House declared.

General Practice Residencies

Eight resolutions were introduced on the subject of creating new two-year, residency training programs in general practice. The House agreed that there appears to be a need for such programs for those individuals who desire more experience in obstetrics and surgery than may be available in the currently existing Family Practice Program. It approved a substitute resolution directing the Council on Medical Education and Hospitals to consider for approval other two-year programs in general practice which incorporate experience in obstetrics and surgery. The Council will review these programs on the basis of their individual merits and conduct a long-range evaluation of the new programs as well as the previously established Family Practice Programs.

Relations With Other Health Professions and Services

The House considered a Board report and twelve resolutions dealing with various aspects of medicine's relationships with allied health professions and services, including optometry. The Board report recommended the creation of a new AMA Council to handle all the problems involved. The House, however, accepted a reference committee suggestion for establishment of a new Commission to Coordinate the Relationships of Medicine with Allied Health Professions and Services. The Commission will be composed of seven

members appointed by the Speaker of the House. Subcommittees, composed of from three to five members selected by the Commission from lists of names submitted by the scientific sections, will consider problems in specific areas. The Commission will correlate and catalogue the reports of the subcommittees and will act as liaison agent between the subcommittees and those AMA Councils where there may be overlapping interests.

Polio Vaccine

The House approved a report by the Council on Drugs on the present status of poliomyelitis vaccination in the Uinted States and urged that it be made available to all physicians through the most effective communications media. The report clearly outlines procedures recommended for implementation of mass vaccination with the new oral vaccine when it becomes available. The House complimented the Council on its "clear and succinct statement on the initiation of the new campaign which will be needed to promote the new vaccine." The House agreed that the report provides the practicing physician with a reliable series of answers to the many questions which will arise during the change-over from Salk vaccine to oral vaccine. The report emphasizes, however, that "physicians should encourage, support and extend the use of Salk vaccine on the widest possible scale at least until the oral polio-virus vaccines currently under development and clinical trial become available."

Guides to Physician Relationships with Medical Care Plans

The House approved these guides submitted by the Council on Medical Service, with two changes. In the debate on this matter, Doctor Long urged that item 5 under "Responsibilities of the Medical Society" be deleted. Item 5 stated "To recognize that properly qualified physicians employed by, or otherwise serving, medical care plans should not be denied professional rights and privileges because of their service to such plans, and addition of a new item 1 under "Responsibilities of the Medical Care Plan," which reads: "To provide the beneficiary of the plan with free choice of qualified physicians";

Miscellaneous Actions

Reaffirmed its support of the *Kerr-Mills* program for the needy and near-needy aged and its opposition to any legislation of the *King-Anderson* type, declaring that the medical profession "will not be a willing party to implementing any system which we believe to be detrimental to the public welfare";

Approved a markedly expanded *drug information program* submitted by the Board of Trustees and the Council on Drugs;

Adopted the final report of the *Special Study Committee* of the Council on Medical Education and Hospitals and recommended that copies be sent to all medical school deans in the United States;

Decided to hold the *1963 Clinical Meeting* in Portland, Oregon, instead of Las Vegas, Nevada, as recommended by the Board;

Approved a plan by the new AMA Department of International Health to cooperate in the recruitment of volunteer physicians for emergency medical service in *foreign mission fields;*

Agreed to an increase of $20 in the annual AMA *membership dues* to be implemented over a period of two years; $10 on January 1, 1962, and $10 additional on January 1, 1963;

Discontinued the Association's *General Practitioner* of the *Year* award;

Opposed legislative and administrative mandates which would compel physicians to prescribe drugs, or require pharmaceuticals to be sold, by *generic names* only;

Reaffirmed the Association's opposition to compulsory inclusion of physiicans under the *Social Security* system;

Urged immediate legislation that will provide strong economic motivation for the construction and maintenance of *fallout shelters;*

Disapproved two resolutions which would have discontinued the scientific activities at the *Clinical Meeting;*

Urged *immunization campaigns* against both tetanus and influenza, and

Asked state and county medical societies to give full support to the *First National Congress on Medical Quackery* to be jointly sponsored next October 6-7 in Washington, D. C., by the AMA and the Food and Drug Administration.

The AMA 1961 Distinguished Service Award was voted to Dr. Walter H. Judd of Minneapolis, physician and member of Congress, for his contributions as a medical missionary, humanitarian and statesman devoted to world peace.

Total registration through Thursday, with half a day of the meeting still remaining, had reached 56,315, including 22, 681 physicians.

George F. Brockman, M.D.
Robert C. Long, M.D.
W. Vinson Pierce

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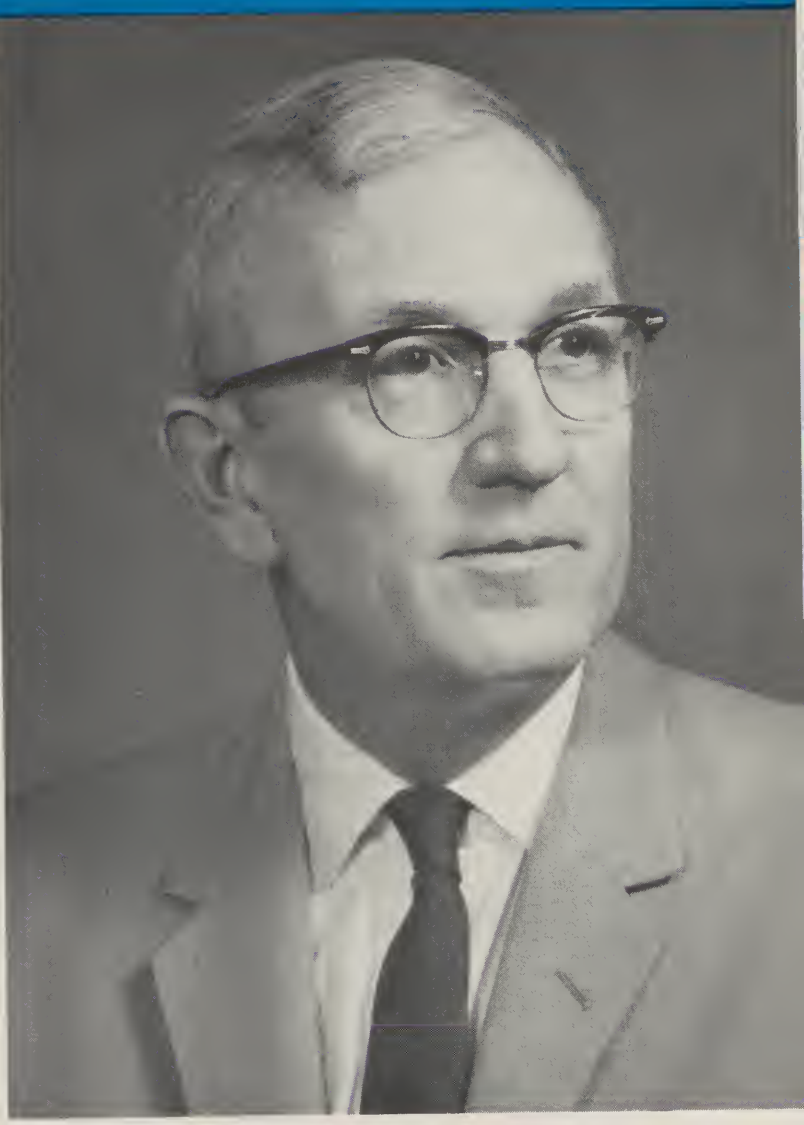
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KSMA OFFICERS

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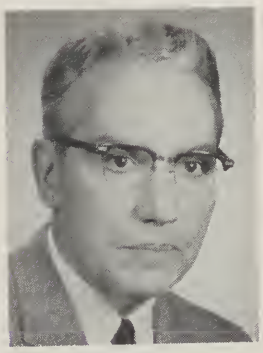
Richard G. Elliott, M.D.
President



Foster D. Coleman, M.D.
Vice President—Central



Wendell V. Lyon, M.D.
Vice President—Eastern



James T. Gilbert, M.D.
Vice President—Western

President-Elect
Gaithel L. Simpson, M.D., Greenville

The installation of Doctor Simpson as president of the Kentucky State Medical Association will take place Wednesday evening, September 20, during the 1961 Annual Meeting in Louisville.

Doctor Simpson, who does general surgery in Greenville, was born in 1905 and received his early education in Christian County. He then attended the University of Louisville where he received his medical degree from the School of Medicine in 1931. He took postgraduate training at Louisville General Hospital.

An active member of the KSMA, Doctor Simpson has served one term as Vice President, Western. He has held numerous committee assignments, including the chairmanship of the Medical Service Committee for several years. He is currently chairman of the Governor's Advisory Council on Indigent Medical Care. He was one of the founders and is Vice Chairman of the KSMA Medical Student Scholarship Loan Fund.

He has received the American Cancer Society Award for Kentucky and holds membership in the following associations: Muhlenberg County Medical Society, Kentucky Surgical Association, American Medical Association, American College of Surgeons and Southeastern Surgical Congress.

In addition to his activities in the medical profession, Doctor Simpson is active in civic affairs. He has served for ten years on the Greenville Independent School Board, and is interested in soil and water conservation in western Kentucky. He is currently chairman of the East Fork Pond River Watershed Conservation District, embracing 140,000 acres in three counties.

He is married to the former Susan Forrest Cather and they have two sons and two daughters: Gaithel, 22, who is married and has a daughter; Dan, 20; Peggy, 18; and Alice, 16.

VICE PRESIDENT, CENTRAL
Foster D. Coleman, M.D.,

Doctor Coleman, a native of Pike County, attended the University of Kentucky preparatory to going to the University of Louisville where he received his medical degree from the School of Medicine in 1934. He interned at Louisville General Hospital and took his residency training at Cook County Hospital, Chicago. He is assistant professor of medicine at the U. of L. School of Medicine, has been an alternate delegate to the AMA and is past president of the Jefferson County Medical Society. Doctor Coleman limits his practice to internal medicine.

VICE PRESIDENT, EASTERN
Wendell V. Lyon, M.D., Ashland

A 1943 graduate of the University of Louisville School of Medicine, Doctor Lyon had previously attended Centre College, Danville. He served a rotating internship at Louisville General Hospital, and held the rank of captain in the U. S. Army, serving in the Pacific area during World War II. He began practicing general medicine in Ashland in 1946, and has limited his practice to general surgery since 1952. The son of O. L. Lyon, M.D., who was formerly head of Eastern State Hospital, Dr. Lyon is on the staffs of Kings' Daughters' and Our Lady of Bellefonte Hospitals, in Ashland.

VICE PRESIDENT, WESTERN
James T. Gilbert, M.D., Bowling Green

Doctor Gilbert, a 1934 graduate of the Vanderbilt University School of Medicine, limits his practice to internal medicine in Bowling Green. He interned and took his residency at Nashville General Hospital. He became a Diplomate of the American Board of Internal Medicine in 1941 and a Fellow of the American College of Physicians in 1943. In 1952 Doctor Gilbert became chief of the medical staff, Bowling Green-Warren County Hospital and chief of medicine at that hospital in 1953. He is a past president of the Warren, Edmonson, Butler County Medical Society and of the Sixth District Medical Society.

KSMA Secretary and Treasurer

SECRETARY

Woodford B. Troutman, M.D., Louisville



Doctor Troutman was elected to his first full five-year term as secretary of the KSMA in 1958 after two years as interim secretary and 12 years as treasurer. He graduated from the University of Louisville School of Medicine in 1921, and interned at McKeesport Hospital in Pennsylvania and Bellevue Hospital in New York. After five years of general practice in Louisville, he took post-graduate training in cardiology in Europe, returning to practice that specialty in Louisville in 1930. He is active in the American Heart Association and is a Fellow of the American College of Physicians.

TREASURER

Delmas M. Clardy, M.D., Hopkinsville



Doctor Clardy was elected treasurer in 1958 after six years as a District Councilor. He has been a KSMA delegate since 1936, and is past president of the Christian County Medical Society. A native of Tennessee, he is a 1932 graduate of the University of Louisville School of Medicine. He is a general surgeon, a Fellow of the American College of Surgeons, and a member of the Kentucky Surgical Society and the Southeastern Surgical Congress. He served in the U.S. Army for four years during World War II.

KSMA Journal Editors

EDITOR

Sam A. Overstreet, M.D., Louisville

Doctor Overstreet was named editor of the Journal in 1958 following the retirement of the late Guy Aud, M.D. He first served the Journal as scientific editorial editor. A 1923 graduate of the University of Louisville School of Medicine, he has also served the KSMA as Centennial president in 1950-51. Doctor Overstreet has been president of the Jefferson County Medical Society and governor of the Kentucky Chapter, American College of Physicians. He is chairman of the KSMA Advisory Committee to the Blue Cross Plan and president of the staff of Louisville's Methodist-Evangelical Hospital.

(A picture of Doctor Overstreet, who is also Speaker of the House, appears on page 766.)

ASSOCIATE EDITOR

George W. Pedigo, Jr., M.D., Louisville



Doctor Pedigo has served the KSMA and the Jefferson County Medical Society in many capacities. Associate editor since 1958, he has also been Vice Speaker of the House of Delegates. He has served the Jefferson County Society at various dates as president, secretary and treasurer. A 1938 graduate of the University of Louisville School of Medicine, he is now a member of the faculty of that school. He is a diplomate of the American Board of Internal Medicine and has been president of the Kentucky Society of Internal Medicine. Doctor Pedigo was elected to the Board of Directors of the Kentucky Chamber of Commerce and is the first physician to serve in that capacity.

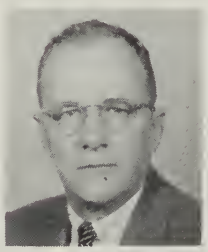
AMA Delegates

W. Vinson Pierce, M.D., Covington



Re-elected KSMA delegate to the AMA for his third term in 1959, Doctor Pierce is a 1934 graduate of the University of Louisville School of Medicine. He is a past president of the Kentucky Surgical Society, Kentucky Chapter, American College of Surgeons, and Kentucky Physicians Mutual, Inc. He is presently chairman of the KSMA Advisory Committee to Blue Shield and has served on the AMA Insurance Committee since 1958. Earlier this year Doctor Pierce was appointed one of three AMA representatives on the Joint Commission for the Promotion of Voluntary Non-Profit Prepayment Health Plans.

Robert C. Long, M.D., Louisville



Appointed delegate in December, 1957, to fill the unexpired term of the late Clark Bailey, M.D., Doctor Long was elected to his first full term in 1958. Active in medical affairs on the county, as well as the state level, he has served Jefferson County Medical Society in many posts and has also been president of the Louisville Obstetrical Society. He graduated from the University of Louisville School of Medicine in 1940 and took his internship and part of his residency training at Louisville General Hospital. He completed his residency training at Chicago Lying-In-Hospital. Earlier this month he presented the KSMA testimony on the King Bill before the House Ways and Means Committee.

AMA Delegates

George F. Brockman, M.D., Greenville

The KSMA qualified for a third delegate and alternate delegate to the AMA and Doctor Brockman was appointed in April. A Greenville physician since 1946, Doctor Brockman graduated from the University of Louisville School of Medicine in 1935. He served with the military forces in the North Pacific between 1942 and 1946. He has served on numerous committees of the KSMA and is presently chairman of the Building Committee. He is secretary of the Muhlenberg County Board of Health and a member of the Medical Staff of the Muhlenberg Community Hospital. He also serves his community as a member of the American Legion, Greenville Post No. 80, and was an Incorporator of the Muhlenberg County Chamber of Commerce.



KSMA Official Historian

Emmet Field Horine, M.D., Brooks

As official KSMA historian, Doctor Horine writes for the Annual Meeting Program each year biographical material on the past president of the KSMA to be honored at that meeting. He has done this since the practice was begun many years ago, and has copies of all the biographies he has written. He is also working with the KSMA Building Committee as a consultant on the appropriate use of old medical literature and souvenirs in the new building. Doctor Horine, a 1907 graduate of the University of Louisville School of Medicine, has retired from a practice limited to cardiovascular disease and internal medicine.



New Trustees

EIGHTH DISTRICT
Dexter Meyer, Jr., M.D., Covington

Doctor Meyer, a native of Bracken County, received his medical degree from the University of Louisville School of Medicine in 1944 after having previously attended Transylvania College. He then took specialist training in ophthalmology at the Washington University School of Medicine from 1950 to 1953. His Covington practice is limited to opthalmology. Doctor Meyer is on the staffs of St. Elizabeth and Booth Hospitals, Covington, and is clinical instructor in ophthalmology at the University of Cincinnati Medical School.

ELEVENTH DISTRICT
Hubert S. Jones, M.D., Berea

A 1943 graduate of the University of Louisville School of Medicine, Doctor Jones had previously attended Eastern State College. He interned at St. Elizabeth Hospital, Covington, and took one year of residency training in Ob and Gyn at Louisville General Hospital and another year of residency in General Surgery at St. Joseph Hospital, Lexington. He served a three-year preceptorship in General Surgery at the Lexington Clinic. Doctor Jones' Berea practice is limited to General Surgery. He also served with the Armed Forces during World War II.

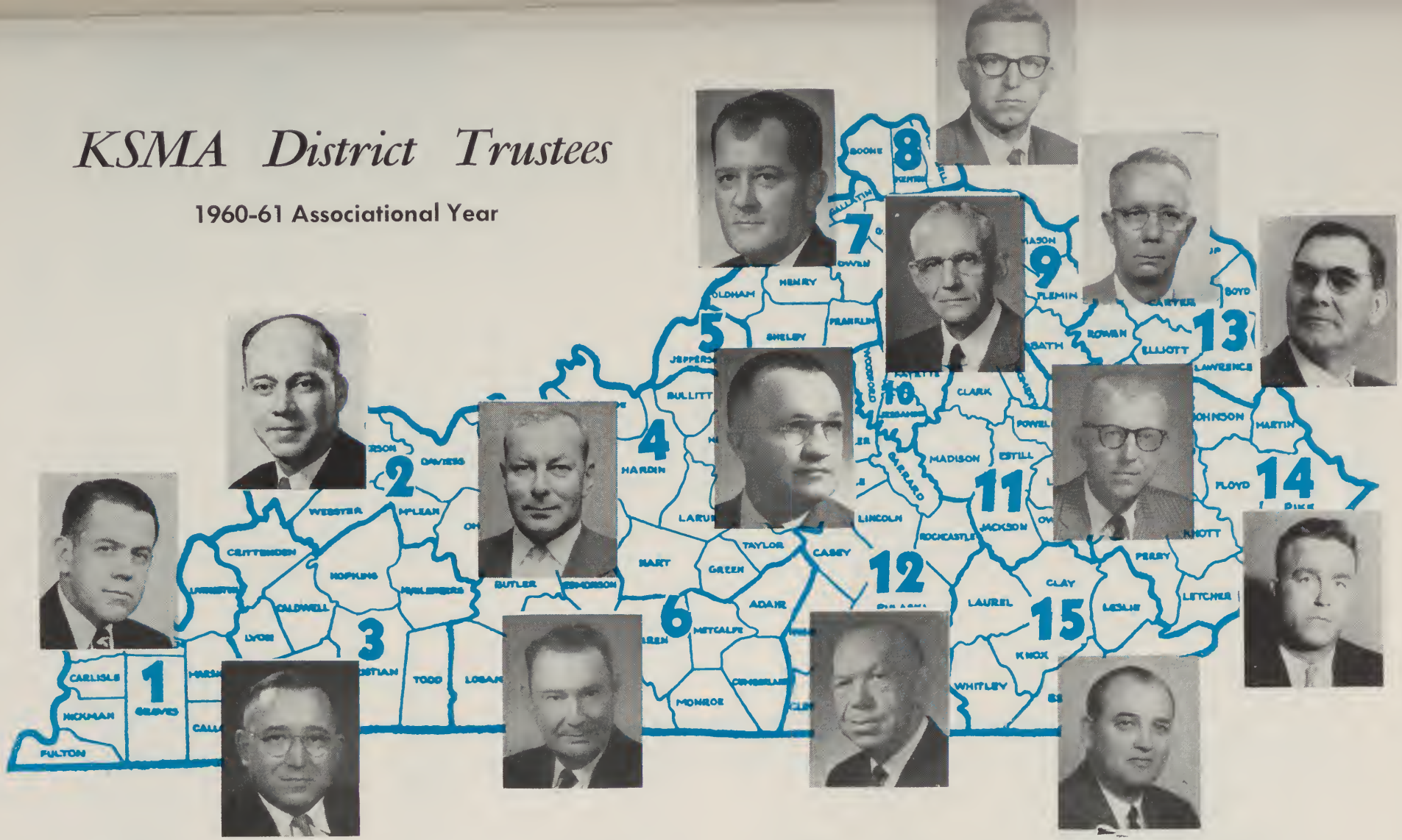
Election of Trustees

Trustees for five KSMA Districts will be elected by the House of Delegates at its second session on Thursday, September 21. Nominations will be made at a caucus of the delegates from each district immediately after the first session of the House on September 19. Each committee will report its nominees at the beginning of the second scientific session on Thursday, September 21. Further nominations may be made from the floor. The five districts are: **Second District** (incumbent, Walter L. O'Nan, M.D., Henderson); **Seventh District** (incumbent, Wyatt Norvell, M.D., New Castle); **Ninth District** (incumbent, J. M. Stevenson, M.D., Brooksville); **Tenth District** (incumbent, Douglas E. Scott, M.D., Lexington); and **Thirteenth District** (incumbent, Charles B. Johnson, M.D., Russell). Doctors O'Nan, Stevenson, and Johnson have each served two consecutive terms as District Trustee. Since the by-laws state that a trustee may succeed himself only once, the only incumbents eligible for re-election are Doctors Norvell and Scott. Biographical information on new trustees elected in 1960 appears above.

See map on next page——→

KSMA District Trustees

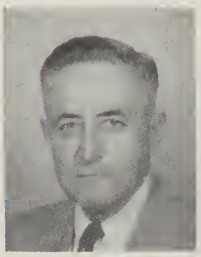
1960-61 Associational Year


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CARLISLE
HICKMAN
FULTON
GRAVES
CALLOWAY
CHRISTIAN
TODD
LOGAN
WARREN
BUTLER
EDMONSON
HART
GREEN
TAYLOR
CASEY
ADAIR
METCALFE
MONROE
CUMBERLAND
LINCOLN
ROCKCASTLE
PULASKI
WAYNE
WHITLEY
KNOX
LAUREL
JACKSON
CLAY
LESLIE
LETCHER
PERRY
KNOTT
FLOYD
MARTIN
JOHNSON
LAWRENCE
BOYD
CARTER
ELLIOTT
ROWAN
BATH
MENIFEE
MORGAN
FLEMING
MASON
LEWIS
GREENUP
BRACKEN
ROBERTSON
MERCER
BOYLE
MADISON
ESTILL
POWELL
CLARK
MONTGOMERY
WOODFORD
FAYETTE
JESSAMINE
GARRARD
BOURBON
SCOTT
FRANKLIN
SHELBY
OLDHAM
HENRY
TRIMBLE
GALLATIN
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BOURBON
MASON
FLEMING
LEWIS
GREENUP
CARTER
BOYD
LAWRENCE
JOHNSON
MARTIN

Officers of the KSMA House of Delegates

SPEAKER

Sam A. Overstreet, M.D., Louisville



The fourth member to hold the office of Speaker since the reorganization of procedure in the House of Delegates, Doctor Overstreet was elected to that office at the 1959 session. He has served the state group in various capacities and is also active in the Jefferson County Medical Society of which he was president in 1947. He is chairman of the KSMA Advisory Committee to Blue Shield and has served as governor of the Kentucky Chapter, American College of Physicians.

VICE SPEAKER

Garnett Sweeney, M.D., Liberty



Doctor Sweeney was elected vice speaker at the 1959 Annual Meeting after having served as chairman of the KSMA Council. He had also served on the Council's executive committee. He completed his second term as councilor in 1959. A 1939 graduate of the University of Louisville School of Medicine, he interned at Charity Hospital in New Orleans and began practice in his native Liberty in 1940. In 1954, Doctor Sweeney was president of the Kentucky Chapter, American Academy of General Practice.

KSMA Delegates

ADAIR
James C. Salato, Columbia

ALLEN
Victor E. Scherer, Scottsville

ANDERSON
Boyd H. Caudill, Lawrenceburg

BALLARD
Jesse M. Hunt, Jr., Wickliffe

BARREN

BATH

BELL
Charles B. Stacy, Pineville

BOONE
Joseph F. Daugherty, Florence

BOURBON
Richard J. Wever, Paris

BOYD
Clyde C. Sparks, Ashland
Guy C. Cunningham, Ashland

BOYLE
Chrisman S. Jackson, Danville

BRACKEN

BREATHITT
Price Sewell, Jr., Jackson

BRECKINRIDGE
James G. Sills, Hardinsburg

BULLITT

BUTLER
David G. Miller, Jr., Morgantown

CALDWELL

CALLOWAY
John C. Quertermous, Murray

CAMPBELL-KENTON
Robert J. Hoffman, S. Ft. Mitchell
John J. Rolf, Covington
W. Donald Janney, Covington
William T. McElhinney, Covington
Richard A. Allnutt, Covington
Paul H. Klingenberg, Covington
James J. Kelly, Covington

CARLISLE
John T. O'Neill, Arlington

CARROLL
James O. Mattax, Carrollton

CARTER
J. Watts Stovall, Grayson

CASEY

CHRISTIAN
Gabe A. Payne, Jr. Hopkinsville
Harvey B. Stone, Hopkinsville

CLARK
Robert L. Davis, Winchester

CLAY
William E. Becknell, Manchester

CLINTON
Floyd B. Hay, Albany

CRITTENDEN

CUMBERLAND
Norman K. Kirby, Burkesville

DAVIESS
Loran P. Moore, Jr., Owensboro
John S. Oldham, Owensboro
William L. Woolfolk, Owensboro

EDMONSON

ELLIOTT
John F. Greene, Sandy Hook

ESTILL
Richard R. Snowden, Ravenna

FAYETTE
Nathaniel L. Bosworth, Lexington
Matthew C. Darnell, Jr., Lexington
Robert B. Warfield, Lexington
Ernest C. Strode, Lexington
Joseph H. Saunders, Lexington
Carl H. Fortune, Lexington
Maurice Kaufmann, Lexington
Robert D. Shepard, Lexington
Harvey Chenault, Lexington

FLEMING
Robert W. Fidler, Flemingsburg

FLOYD
Russell L. Hall, Prestonsburg

FRANKLIN
James T. Ramsey, Frankfort

FULTON
R. Ward Bushart, Fulton

GALLATIN
George F. Harris, Warsaw

GARRARD
Paul J. Sides, Lancaster

GRANT
Frederick R. Scroggin, Dry Ridge

GRAVES
William H. Fuller, Mayfield

GRAYSON

GREEN
Robert L. Shuffett, Greensburg

GREENUP

HANCOCK

HARDIN
Charles F. Long, Elizabethtown

HARLAN
E. M. Howard, Jr., Harlan
David McLean Greeley, Harlan

HARRISON
Henry H. Moody, Cynthiana

HART

HENDERSON
Kenneth M. Eblen, Henderson

HENRY
Sydney B. May, Eminence

HICKMAN
Vester A. Jackson, Clinton

HOPKINS
Loman C. Trover, Madisonville
Frederick A. Scott, Madisonville

JACKSON

JEFFERSON
William C. Buschmeyer, Louisville
Kenneth P. Crawford, Louisville
Nathan I. Handelman, Louisville
George B. Kimbrough, Louisville
Daniel E. Mahaffey, Louisville
Henry W. Post, Louisville
Carroll H. Robie, Jr., Louisville

Delegates (continued)

Stanley E. Smith, Louisville
Robert S. Tillett, Louisville
Charles J. Bisig, Louisville
W. Austin Bloch, Louisville
Harold G. Eskind, Louisville
David W. Kinnaird, Louisville
Paul Mapother, Louisville
Harry A. Pfingst, Louisville
George A. Sehlinger, Louisville
David H. Thurman, Louisville
Robert L. Woodard, Jr., Louisville
C. Melvin Bernhard, Louisville
Ralph M. Denham, Louisville
James B. Douglas, Louisville
Robert L. McClendon, Louisville
William E. Oldham, Louisville
Burrel F. Radmacher, Jr., Louisville
Henry G. Saam, Jr., Louisville
George I. Uhde, Louisville
Rudolph F. Vogt, Louisville
William P. Vonderhaar, Louisville

JESSAMINE
James S. Williams, Nicholasville

JOHNSON
James W. Archer, Paintsville

KNOTT
Gene T. Watts, Hindman

KNOX
Francis X. Sommer, Barbourville

LARUE
John D. Handley, Hodgenville

LAUREL
Robert E. Pennington, London

LAWRENCE

LEE

LESLIE

LETCHER
Thurman M. Perry, Jenkins

LEWIS

LINCOLN
Howard I. Frisbie, Stanford

LIVINGSTON

LOGAN
Carlisle V. Dodson, Russellville

LYON
Mortimer H. Moseley, Eddyville

McCRACKEN
Warren E. Sloan, Paducah
Walter R. Johnson, Jr., Paducah
Walker M. Turner, Paducah

McLEAN

MADISON
E. Coleman Whitaker, Berea
Douglas H. Jenkins, Richmond

MAGOFFIN

MARION
Bernard J. Baute, Lebanon

MARSHALL
William J. Colburn, Calvert City

MARTIN

MASON
W. Mountjoy Savage, Maysville

MEADE
George E. Clark, Brandenburg

MENIFEE
Donald L. Graves, Frenchburg

MERCER
George F. Ballard, Harrodsburg

METCALFE
Philip D. Hitchcock, Edmonton

MONROE
Clovis A. Crabtree, Gameliel

MONTGOMERY
Joe M. Bush, Mt. Sterling

MORGAN
Morris L. Peyton, West Liberty

MUHLENBERG
Charles J. Shipp, Greenville

NELSON
Arthur D. Steely, Bardstown

NICHOLAS

OHIO
Oscar Allen, Beaver Dam

OLDHAM

OWEN
Maurice Bowling, Owenton

OWSLEY
Mildred E. Gabbard, Booneville

PENDLETON
Robert L. McKenney, Falmouth

PERRY
Alger B. Pigmon, Hazard

PIKE

POWELL

PULASKI
Barton L. Ramsey, Jr., Somerset

ROBERTSON

ROCKCASTLE
George H. Griffith, Mt. Vernon

ROWAN

RUSSELL
Charles E. Peck, Russell Springs

SCOTT
Robert G. Wheeler, Georgetown

SHELBY
Max D. Klein, Shelbyville

SIMPSON
Lillard F. Beasley, Franklin

SPENCER
William K. Skaggs, Taylorsville

TAYLOR

TODD
Jesse C. Woodall, Trenton

TRIGG
John Futrell, Cadiz

TRIMBLE
Carl Cooper, Jr., Bedford

UNION

WARREN
Harold Keen, Bowling Green
M. Harper Wright, Bowling Green

WASHINGTON
Marcus A. Coyle, Springfield

WAYNE
Frank L. Duncan, Monticello

WEBSTER

WHITLEY
Willard M. Buttermore, Corbin

WOLFE
Paul F. Maddox, Campton

WOODFORD
Benjamin F. Roach, Midway

Visit the Scientific and Technical Exhibits at the Annual Meeting

Open Meeting To Be Held By Nominating Committee

An open meeting of the KSMA Nominating Committee for general officers will follow the close of the first session of the House of Delegates on Monday, September 18. KSMA members wishing to confer with the committee will have an opportunity to do so at this time.

The committee will report its final recommendations at the end of the first scientific session on Tuesday morning, September 19. Additional nominations may be made from the floor without discussion or comment. The House of Delegates will vote on nominees at the close of its second session on Wednesday, September 20.

Members of the nominating committee are: Adolphus D. Butterworth, M.D., Murray; Matthew C. Darnell, Jr., M.D., Lexington; Russell L. Hall, M.D., Prestonsburg; William E. Oldham, M.D., Louisville; and Walker M. Turner, M.D., Paducah.

Reference Committee Activity

At the first meeting of the House of Delegates on September 18, all officers and committee reports and resolutions will be referred to one of seven reference committees by Speaker Sam A. Overstreet, M.D., Louisville. Reference committees will meet at 2 p.m. Tuesday, September 19. All reference committee sessions will be held in **air-conditioned second-floor rooms** of the First Christian Church Annex, conveniently located near Columbia Auditorium. Members of the committees will assemble at 1:45 p.m. for briefing sessions. **Any KSMA member wishing to testify on any resolution is urged to be present at 2 p.m.** Open hearings for each reference committee will last at least an hour to permit all who wish to speak to be heard. Following the open hearings, the committees will go into executive session to study the reports and review the testimony given at the hearings. Recommendations will be made for presentation at the final session of the House in the Brown Hotel Roof Garden on Wednesday night, September 20. The reference committees appointed by Doctor Overstreet to serve during the 1961 session are as follows:

1961 Reference Committee Appointments

REFERENCE COMMITTEE NO. 1

Reports of Officers and Trustees

W. Bruce Hamilton, M.D., Shepherdsville, Chairman
Jesse C. Woodall, M.D., Trenton
Robert J. Hoffman, M.D., South Fort Mitchell
Arthur D. Steely, M.D., Bardstown
Joe M. Bush, M.D., Mt. Sterling

REFERENCE COMMITTEE NO. 2

Reports on Medical Care, Medical Education, Hospitals and Related Subjects

Harold G. Eskind, M.D., Louisville, Chairman
Thurman M. Perry, M.D., Jenkins
J. S. Williams, M.D., Nicholasville
George F. Ballard, M.D., Harrodsburg
William T. McElhinney, M.D., Covington

REFERENCE COMMITTEE NO. 3

Reports on Legislation and Public Relations

Alfred O. Miller, M.D., Louisville, Chairman
Frederick R. Scroggin, M.D., Dry Ridge
Robert W. Fidler, M.D., Flemingsburg
John D. Handley, M.D., Hodgenville
Paul J. Sides, M.D., Lancaster

REFERENCE COMMITTEE NO. 4

Reports on Public Service and Allied Professions

David H. Thurman, M.D., Louisville, Chairman
George I. Uhde, M.D., Louisville
Maurice Kaufmann, M.D., Lexington
Harvey Chenault, M.D., Lexington
Charles F. Long, M.D., Elizabethtown

REFERENCE COMMITTEE NO. 5

Reports on Medical Service

Robert L. Shuffett, M.D., Greensburg, Chairman
David M. Greeley, M.D., Harlan
N. Lewis Bosworth, M.D., Lexington
Burrel F. Radmacher, Jr., M.D., Louisville
Norman K. Kirby, M.D., Burkesville

REFERENCE COMMITTEE NO. 6

Reports on Constitution and Bylaws; Special Committees

Nathan I. Handelman, M.D., Louisville, Chairman
Howard I. Frisbie, M.D., Stanford
Charles J. Shipp, M.D., Greenville
W. Austin Bloch, M.D., Louisville
E. Coleman Whitaker, M.D., Berea

REFERENCE COMMITTEE NO. 7

Reports on Miscellaneous Business

Robert S. Tillett, M.D., Louisville, Chairman
William K. Skaggs, M.D., Taylorsville
James T. Ramsey, M.D., Frankfort
R. Ward Bushart, M.D., Fulton
William E. Becknell, M.D., Manchester

CREDENTIALS COMMITTEE

Carl W. Kumpe, M.D., Covington
Mildred E. Gabbard, M.D., Booneville
David W. Kinnaird, M.D., Louisville

Annual Session High Lights

KSMA Headquarters Sept. 19-21



Columbia Auditorium, 824 S. 4th St., is site of Scientific Sessions and Scientific, Technical Exhibits

• **SCIENTIFIC SESSIONS** are scheduled daily on September 19, 20, 21 at the Columbia Auditorium in Louisville. Outstanding scientific presentations and panel discussions will high-light the three day program.

• **THE HOUSE OF DELEGATES,** the KSMA's policy-making body, will be in session twice during the Annual Meeting —on Monday, September 18, and Wednesday, September 20. Both sessions will be held in the Brown Hotel Roof Garden and will be called to order at 7 p.m., following registration at 5:30 p.m. and a subscription dinner at 6. Officers for 1961-62 will be elected at the second meeting.

• **FOURTEEN SPECIALTY GROUPS** will meet on two days. Seven groups have programs set for Tuesday afternoon, September 19, and seven for Thursday morning, September 21, in the air-conditioned Sunday-School rooms of the First Christian Church. All KSMA members are welcome to attend these programs.

• **PRESIDENT'S LUNCHEON** on Wednesday, September 20, will feature an address by Mr. T. C. Petersen, a member of the American Farm Bureau Federation, Chicago, Ill. Mr. Petersen, who is very much in demand as a speaker, will give a talk on "This Too Is The Practice of Medicine." Presentation of the KSMA's three top awards will be made at the luncheon.

• **LUNCHEON FOR NEW MEMBERS** on Tuesday, September 19, at the Brown Hotel, will be the third annual event honoring the KSMA's new members. All physicians who have joined the Association since September 1, 1960, are invited to attend.

• **ALUMNI REUNIONS,** traditional adjunct of the Annual Meeting, are planned this year by members of 9 graduating classes of the University of Louisville School of Medicine, beginning with the 1911 and including every fifth-year class thereafter except 1916. Separate reunions as instituted last year, will take the place of the customary dinner for all alumni. Members of the class of 1911 will be guests of honor and will receive their 50-year buttons.

Official Call

KSMA Annual Meeting

To the officers and members of the component county societies of the Kentucky State Medical Association.

Meeting Place

The Annual Meeting of the KSMA will convene at the Columbia Auditorium, Louisville, Tuesday, Wednesday, and Thursday, September 19, 20 and 21, 1961. The General Session will be called to order at 9 a.m. Tuesday.

The House of Delegates

The first regular session of the House of Delegates will convene at 7 p.m., Monday, September 18; the second regular session will begin at 7 p.m., Wednesday, September 20. Both sessions will be held in the Roof Garden of the Brown Hotel.

Registration

The registration department will be open in the Roof Garden of the Brown Hotel from 5:30 p.m. to 8 p.m., on Monday, September 18, and Wednesday, September 20. It will be open in the Columbia Auditorium from 8 a.m. to 5 p.m. on Tuesday, September 19; Wendesday, September 20; and Thursday, September 21.

Annual Meeting Woman's Auxiliary to the KSMA

Tuesday, September 19

Preconvention Board Breakfast, 8:45 a.m., Parlors A, B, and C, Brown Hotel; Formal Opening of the 39th Annual Meeting, 10:30 a.m., South Room, Brown Hotel. Subscription Luncheon, South Room, 12:30 p.m. Tea honoring distinguished guests, home of Mrs. Burford Davis, 2 Woodhill Road, 2:30 p.m.

Wednesday, September 20

Final Business Session, 9:30 a.m., South Room, Brown Hotel. Subscription Luncheon—Style Show, 12:30 p.m., Terrace Room, Kentucky Hotel.

Thursday, September 21

Post-convention Board Meeting and Breakfast, 8:45 a.m., South Room, Brown Hotel.

REGISTRATION

You are asked to register at the Registration Booth in the west end of Columbia Auditorium as soon as you are able. Hours are from 8 a.m. to 5 p.m. (EST), Tuesday, Wednesday, and Thursday, September 19, 20, 21.

Please wear your badges at all times while in the Auditorium.

Guests at President's Luncheon Will Hear T. C. Petersen

T. C. Petersen, Chicago, Ill., will discuss "This Too Is The Practice of Medicine" at the annual President's Luncheon in the Crystal Ballroom of the Brown ,Hotel on Wednesday, September 20.



T. C. Petersen

Richard G. Elliott, M.D., Lexington, president of the KSMA, will introduce the speaker who is director of the program development division of the American Farm Bureau Federation.

A native of Iowa, Mr. Petersen is a 1932 graduate of Iowa State College. He is a former high school principal, coach, and vocational agriculture teacher and was state organization director for the Wisconsin Farm Bureau from 1942 until he joined the American Farm Bureau in 1949. He is very much in demand as a speaker and has appeared before various state medical associations, including Ohio and Illinois.

Another feature of the President's Luncheon will be the presentation of awards by KSMA Awards Committee Chairman, William H. Bizot, M.D., Louisville.

Presentation of KSMA Awards Set For President's Luncheon

The three top KSMA awards for 1961 will be presented at the President's Luncheon on Wednesday, September 20, in the Crystal Ballroom of the Brown Hotel. KSMA Awards Committee Chairman William H. Bizot, M.D., Louisville, will make the presentations.

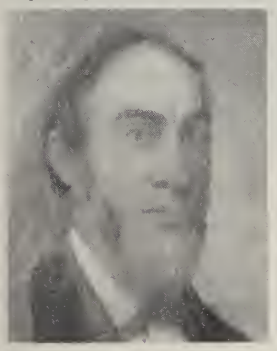
The Awards Committee selects the recipient of the R. Haynes Barr Award and chooses nominees for the Distinguished Service Medal and Outstanding General Practitioner Award. The House of Delegates makes the selection of recipients of the latter two awards from the Awards Committee nominees and any nominations from the floor. Awards Committee members are: Doctor Bizot, chairman; Earl W. Christensen, M.D., Lexington; Theodore Davies, M.D., Barbourville; Horace Harrison, M.D., Owensboro; and W. M. Savage, M.D., Maysville.

Winners of last year's awards were: George P. Archer, M.D., Prestonsburg, the Distinguished Service Medal; John B. Rypstra, M.D., Annville, the Outstanding GP Award; and David Layne Tynes, executive director of Physicians Mutual, Inc., Louisville, received the R. Haynes Barr Award, given each year to a lay person for outstanding contributions in the field of public health and medical care.

Be sure to visit the Scientific and Technical Exhibits while attending the 1961 Annual Meeting of KSMA.

Richard William Dunlap To Be Honored At 1961 Meeting

In 1935, a custom was begun of honoring a past president or some distinguished Kentucky physician each year at the Annual Meeting. This custom will be observed at the Richard William Dunlap Memorial Meeting of the 1961 Annual Meeting in tribute to the 1880 president of the Kentucky State Medical Association.



KSMA historian, Emmet F. Horine, M.D., Brooks, has written an interesting biography of Doctor Dunlap for the program booklet which will be distributed at the Annual Meeting at Columbia Auditorium, Louisville, September 19, 20 and 21.

The 1960 meeting honored Charles H. Todd who was president of the Association in 1879.

Miniature of Fayette W. Dunlap

Our official KSMA historian, Emmet Field Horine, M.D., Brooks, has based all of the biographies of our past presidents on material obtained from their descendants and other primary sources. In preparing the sketch of our president honored in 1961, Richard William Dunlap, M.D., Doctor Horine finally located a relative in St. Louis, Mrs. James Harold Batchelor. She owns an oil portrait of Richard W. Dunlap, M.D., and his wife of which she is giving us a copy.

In addition, Mrs. Batchelor is presenting to the Association a miniature of Fayette W. Dunalp, M.D., who was our Assistant Secretary in 1885, 1886, and 1888. We are sure that other relatives of our officers will be guided by Mrs. Batchelor's generosity and make available important mementos in their possession.

Class Reunions Planned During Annual Meeting

The classes of 1911, 1921, 1926, 1931, 1936, 1941, 1946, 1951, and 1956 of the University of Louisville School of Medicine are planning alumni reunions as part of the Annual Meeting Activities. The class of 1916 is the only fifth-year class not to meet this year.

Following the pattern of previous years, reunions will be held separately by each class according to Les Shively, director of alumni relations at the University.

The class of 1911 will be honored as it marks its golden anniversary. Members of the class will be recognized at the President's Luncheon in the Crystal Ballroom of the Brown Hotel, on Wednesday, September 20, and will sit at a special table, it was announced by Richard G. Elliott, M.D., Lexington, president of the KSMA.

Special tables will also be provided for other classes holding reunions who request them.

For further information about the reunion of your class, contact your chairman:

1911—Oscar O. Miller, M.D., Heyburn Building, Louisville, and Carl C. Howard, M.D., Glasgow.

1921—DeLou P. Hall, M.D., Heyburn Building, Louisville.

1926—Armand K. Fischer, M.D., Heyburn Building, Louisville.

1931—William K. Keller, M.D., Louisville

1936—George J. McAuliffe, M.D., Medical Arts Building, Louisville.

1941—Frederick C. Ehrman, M.D., Heyburn Building, Louisville.

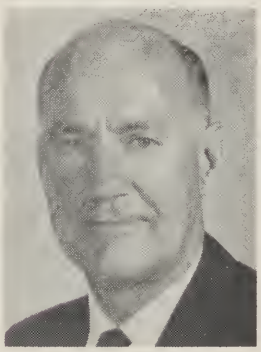
1946—McHenry S. Brewer, M.D., Louisville

1951—Lyle Havens, M.D., 432 Wall Street, Jeffersonville, Indiana.

1956—Henry C. Jackson, II, M.D., 278 Evangeline, Louisville and William P. Vonderhaar, 1329 Story Ave., Louisville.

Dr. Annis Will Speak Twice In Louisville

Edward R. Annis, M.D., a Miami, Fla. surgeon, who testified before the House Ways and Means Committee last month and who received fame for his debate with Senator Humphrey on the King-Anderson Bill, will speak at least twice the last day of the Annual Meeting.



Doctor Annis

He is to speak before the Downtown Rotary Club on "Government Paternalism vs. Individual Responsibility." That evening the Jefferson County Medical Society, with the close co-operation of the KSMA, is presenting him at a public meeting where his topic will be "Medical Aid for the Aged." Location of the evening meeting was undetermined at press time.

Doctor Annis is a native of Detroit, Mich., and received his medical degree from Marquette University School of Medicine, Milwaukee, Wis., in 1938. He has a private practice limited to general surgery and gynecology and is chief of the department of surgery of Mercy Hospital, and an attending surgeon at the North Shore Hospital, Miami.

Breakfast Set For Sept. 20

A breakfast will be held for the Muldraugh Hill Medical Society and International College of Surgeons on Wednesday morning, September 20, at 7:30 a.m. in the Louis Sixteenth Room of the Brown Hotel, according to Joseph C. Ray, M.D. Speaker at the breakfast will be Warner F. Bowers, M.D., Assistant Executive Director of the International College of Surgeons, who will discuss activities of the College

Election of Officers To Be Held September 20

Election of officers of the KSMA for 1961-62 will take place at the second session of the House of Delegates on Wednesday night, September 20. Officers to be chosen are:

President-elect: (Central) one year
Vice Presidents: (Central) one year
(Eastern) one year
(Western) one year

Delegates to the AMA: two years (W. Vinson Pierce, M.D., Covington, and George F. Brockman, M.D., Greenville, incumbents)

Alternate delegates to the AMA: two years (J. Vernon Pace, M.D., Paducah, and John Quertermous, M.D., Murray, incumbents)

Trustees: three years—trustees are to be elected for the following Districts:

Second District (Walter L. O'Nan, M.D., Henderson, has served two consecutive terms and is not eligible for re-election)

Seventh District (Wyatt Norvell, M.D., New Castle, incumbent)

Ninth District (J. M. Stevenson, M.D., Brooksville, has served two consecutive terms and is not eligible for re-election)

Tenth District (Douglas E. Scott, M.D., Lexington, incumbent)

Thirteenth District (Charles B. Johnson, M.D., Russell has served two consecutive terms and is not eligible for re-election)

The KSMA has qualified for a third delegate and alternate delegate to the AMA. Doctor Brockman and Doctor Quertermous were elected by the Board of Trustees in April to serve out the year in these posts respectively.

Luncheon Set For Sept. 19 For New KSMA Members

The third annual luncheon for new members of the KSMA will be held in Parlors A, B, and C of the Brown Hotel on Tuesday, September 19, according to N. L. Bosworth, M.D., Lexington, chairman of the KSMA Committee on Public Information and Service.

A panel discussion on services offered by the KSMA is on the program for the luncheon. Doctor Bosworth will act as moderator. Panelists will be: Carl Fortune, M.D., Lexington, speaking on "The Purpose of the KSMA"; Hoyt D. Gardner, M.D., Louisville, discussing "Services the KSMA Renders Its Members," and Wyatt Norvell, M.D., New Castle, talking on "Services the KSMA Offers the Public."

Invitations will be issued to physicians who have joined the Association since September 1960. Doctor Bosworth urges all new members to accept the invitations and attend the luncheon.

A list of all new members will appear in the September issue of he Journal.

While at the Annual Meeting . . . .

Four Special Phones

will keep you in touch with

Home or Office

You may be easily reached while attending the KSMA annual sessions, if you leave the **special phone numbers** listed below at your home and office, along with your schedule.

JUniper 3-1933 is the special KSMA number at Columbia Auditorium at the KSMA Headquarters Office, where all general scientific sessions will be held.

JUniper 4-6377 and **JUniper 4-6378** are the special numbers for physicians attending meetings at the First Christian Church. If you plan to attend any of five specialty group sessions or seven reference committee meetings at First Christian Church Tuesday afternoon, September 19—only—Call JU 4-6377 or JU 4-6378.

Or, if you plan to attend any of the five specialty group meetings at the First Christian Church Thursday morning, September 21, only—call JU 4-6377 or JU 4-6378.

Do not call the First Christian Church number! Call either of our official numbers at the Church—JU 4-6377 or JU 4-6378.

JUniper 4-1311 Roof Garden Kitchen extension is the special number to be called if you want to be reached either Monday evening, September 18, or Wednesday evening September 20, while attending the meetings of the KSMA House of Delegates in the Roof Garden of the Brown Hotel.

1961 Annual Meeting Program Summary

The Kentucky State Medical Association

September 18, 19, 20 and 21

Louisville

MONDAY, SEPTEMBER 18

12:30 noon	Board of Trustees Meeting	Louis XVI Room, Brown Hotel
5:30 p.m.	Registration, House of Delegates	Roof Garden, Brown Hotel
6:00 p.m.	Subscription Dinner, House of Delegates	Roof Garden, Brown Hotel
7:00 p.m.	First Meeting of House of Delegates	Roof Garden, Brown Hotel

TUESDAY, SEPTEMBER 19

8:00 a.m.	Registration	Columbia Auditorium
8:45 a.m.	Opening Ceremonies	Columbia Auditorium
9:00 a.m.	First Scientific Session	Columbia Auditorium
9:40 a.m.	President's Address	Columbia Auditorium
11:10 a.m.	Panel Discussion	Columbia Auditorium
12:15 p.m.	Annual Luncheon for New Members	Parlors A, B, and C, Brown Hotel
2:00 p.m.	Specialty Group Sessions (Seven specialty groups will meet simultaneously. Any KSMA member may attend any of these meetings. See pages 774-776 in program.)	
	Reference Committee Meetings	First Christian Church Annex

WEDNESDAY, SEPTEMBER 20

9:00 a.m.	Second Scientific Session	Columbia Auditorium
10:50 a.m.	Panel Discussion	Columbia Auditorium
11:50 a.m.	President's Luncheon	Ballroom, Brown Hotel
2:00 p.m.	Third Scientific Session	Columbia Auditorium
5:00 p.m.	Board of Trustees Dinner	Louis XVI Room, Brown Hotel
5:30 p.m.	Registration, House of Delegates	Roof Garden, Brown Hotel
6:00 p.m.	Subscription Dinner, House of Delegates	Roof Garden, Brown Hotel
7:00 p.m.	Second Meeting, House of Delegates	Roof Garden, Brown Hotel

THURSDAY, SEPTEMBER 21

9:30 a.m.	Specialty Group Sessions (Seven specialty group programs will be held simultaneously. Any KSMA member may attend any of these meetings. See pages 777-778 in program.)	
12:00 noon	Board of Trustees Luncheon	Parlors A, B, and C, Brown Hotel
2:00 p.m.	Fourth Scientific Session	Columbia Auditorium
3:30 p.m.	Panel Discussion	Columbia Auditorium
5:00 p.m.	Adjournment	

A 30-minute intermission has been scheduled during each morning and afternoon Scientific Session for visiting the Scientfic and Technical Exhibits.

(Full Scientific Program starts on page 774)

SCIENTIFIC PROGRAM

Richard William Dunlap Memorial Meeting

The Kentucky State Medical Association

Columbia Auditorium, Louisville

TUESDAY, SEPTEMBER 19

Registration

8:45 **Opening of General Session**
Call to Order by the President
Richard G. Elliott, M.D., Lexington
Invocation
Dr. Walter E. Lawrenson, Pastor, Beargrass Christian Church, Louisville
Welcoming Remarks
Daniel G. Costigan, M.D., Louisville, President, Jefferson County Medical Society

FIRST SCIENTIFIC SESSION

COLUMBIA AUDITORIUM

9:00 **"Obstetrical Emergencies"**
Conrad G. Collins, M.D., New Orleans, La.

9:20 **"Unusual Patterns in Common Pulmonary Disease"**
Jerome F. Wiot, M.D, Cincinnati, Ohio

9:40 **President's Address**
Richard G. Elliott, M.D., Lexington, KSMA President

10:00 **Visit Exhibits**

10:30 **"Volatile Anesthetics and Drugs Used in Mental Illness"**
John C. Krantz, Ph.D., Baltimore, Md.

10:50 **"Hyperkinetic Behavior Disorders in Children"**
William Langford, M.D., New York City

11:10 **Panel—"Behavioral Disorders in Children"**
Kenneth Crawford, M.D., Louisville, Moderator
William Langford, M.D., New York City
Lovick Miller, Ph.D., Louisville
Joseph B. Parker, M.D., Lexington
Frederick Horner, M.D., Lexington

12:15 **Luncheon**

Specialty Group Meetings

Seven specialty groups will present scientific programs simultaneously and there will be no general session. Programs will be held either in the First Christian Church, the Columbia Auditorium, or Calvary Episcopal Church.

Mectings will start at 2:00 p.m., and KSMA members are free to go from one group to another during the sessions.

Kentucky Society of Anesthesiologists

First Christian Church, Room #44

2:00 **"Fluothane for Spinal Fusion"**
George W. Schafer, M.D., Louisville

2:30 **"Anesthesia for Tonsillectomy in Children"**
C. B. Theiss, Jr., M.D., Louisville
W. N. Bennett, M.D., Louisville

GUEST SPEAKERS

CONRAD G. COLLINS, M.D.

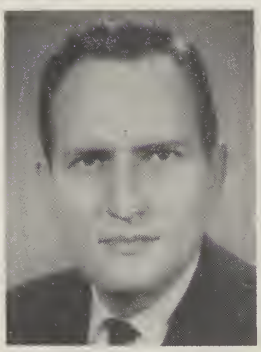
New Orleans, La.



Professor and chairman, department of obstetrics and gynecology, Tulane University School of Medicine; abstetrician and gynecalogist-in-chief, Tulane Unit, Charity Hospital of Louisiana; graduate of Tulane University School af Medicine with M.D. degree, 1928; National Consultant to the Surgean General, U.S. Air Force; consultont ta the Veterans Administration in New Orleans; member of American Gynecalagical Society, American College of Surgeons, American Associatian of Obstetricians and Gynecalogists, American College af Obstetricians and Gynecalogists; served in United States Army 1942-46 with rank af major.

JAMES F. WIOT, M.D.

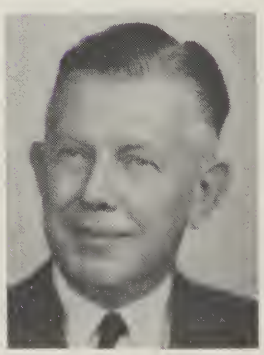
Cincinnati, Ohio



Assistant professor of radiology, University af Cincinnati, School of Medicine; assistant director of radiology, Cincinnati General Haspital; attending radiologist, Cincinnati Veterans Administration Hospital; graduate, University of Cincinnati Schoal af Medicine with M.D. degree, 1953; internship, Cincinnati General Hospital, 1953-4; residency, Cincinnati General Hospital, 1954-5, 1957-9; diplomate, American Callege af Radiology; member, American College of Radiology; in general practice, 1955-7; served in U.S. Navy, 1945-6.

JOHN C. KRANTZ, JR., PH.D.

Baltimore, Md.



Professor and chairman, University of Maryland, School af Medicine; B. S. degree 1923, M. S., 1924, Ph. D., 1928, University of Maryland; Director of Research, Pharmaceuticol Chemistry, Sharp and Dohme; 1927-30; Chief of Bureau of Chemistry, Sharp and Dohme, partment af Health, 1930-35; Member Revisions Committee, United States Pharmacapeia, 1930 ta present, secretary 1940-50; Consultant Toxicologist, U.S. Armed Forces, 1942-46; Member of Governor's Cammission an Poisonous Fumes, 1949-55; member Advisory Council, Nationol Research Cauncil, 1959 ta present; member American Society for Pharmacology and Experimental Therapeutics.

3:00 "Dynamics of Uptake and Distribution of Diethyl Ether"
Thomas N. MacKrell, M.D., Louisville
3:30 "The Volatile Anesthetic Agents Containing Fluorine"
John C. Krantz, Jr., M.D., Baltimore, Md.

Kentucky Chapter, American College of Chest Physicians
Kentucky Radiological Society

Columbia Auditorium

2:00 "Basic Chest Diagnosis From An Internist's Standpoint"
Virgil A. Plessinger, M.D., Cincinnati
2:30 "Roentgen Findings in Obstructed Diaphragmatic Hernia"
Jerome F. Wiot, M.D., Cincinnati
3:00 Visit Exhibits
3:30 Panel Discussion on "Chest Lesions"—Selected Case Reviews
David Shapiro, M.D., Louisville, Moderator
John S. Harter, M.D., Louisville
Virgil A. Plessinger, M.D., Cincinnati
Jerome F Wiot, M.D., Cincinnati

Kentucky Obstetrical and Gynecologic Society

First Christian Church, Choir Room

2:00 "Urological Problems in Ob & Gyn"
Conrad G. Collins, M.D., New Orleans, La.
2:30 Review of Maternal and Child Mortality Study
John A. Petry, M.D., Louisville
3:00 Review of Two Maternal Mortality Cases Followed by a Panel Discussion
William H. Parker, M.D., Owensboro, Moderator
Douglas M. Haynes, M.D., Louisville
Conrad G. Collins, M.D., New Orleans, La.
Edwin P. Solomon, M.D., Louisville

Kentucky Orthopaedic Society

Calvary Episcopal Church

2:00 "Etiology of Post-Surgical Orthopaedic Infections"
David B. Stevens, M.D., Lexington
2:30 "Retrosternal Dislocation of the Clavicle"
Charles F. Wood, M.D., Louisville
James M. Riley, Jr., M.D., Louisville
3:00 "Fat Emboli"
Garrett Pipkin, M.D., Kansas City, Mo.
3:30 "Fracture of Femoral Neck Following Radiation Therapy"
K. Armand Fischer, M.D., Louisville

Kentucky Chapter, American Academy of Pediatrics

First Christian Church, Room #46

2:00 "Headache in Children"
William Langford, M.D., New York City
3:15 "Common Foot Problems in Children"
Eugene Regen, M.D., Nashville, Tenn.
4:00 Business Meeting

Kentucky Chapter, American College of Surgeons

First Christian Church, Room #42

2:00 To Be Announced
James A. Harris, M.D., Paducah
2:30 To Be Announced
William Potter, M.D., Harlan
3:00 To Be Announced
Ben Boone, M.D., Louisville
3:30 Portal Hypertension
Charles G. Child, III, M.D., Ann Arbor, Mich.

WILLIAM S. LANGFORD, M.D.
New York, N.Y.



Director, Pediatric Psychiatric Clinic, Babies Haspital, Columbia-Presbyterian Medical Center; Attending pediatrician, Vanderbilt Clinic; Prafessar, psychiatry, Callege af Physicians and Surgeans, Calumbia University; attending psychiatrist, New Yark State Psychiatric Clinic; graduate, Callege af Physicians and Surgeans, Calumbia University, 1931; internship, St. Eiizabeths Haspital, Washingtan, D. C., Babies Haspital, New Yark, N.Y.; Fellaw in training, Children's Psychiatric Service, Jahns Hapkins Hospital, 1934-5; Assaciate fellaw, American Academy af Pediatrics; Fellaw American Psychiatric Assaciatian; President, American Orthapsychiatric Assaciatian 1960-1; certified, in psychiatry and child psychiatry by the American Baard af Psychiatry and Neuralagy, Inc.; member af the Cammittee an Certificatian in Child Psychiatry af the American Baard.

VIRGIL A. PLESSINGER, M.D.
Cincinnati, Ohio



Medical Directar af Dunham Haspital and head af the Department af Tuberculasis af Cincinnati General Haspital; M.D. degree, University af Cincinnati, Callege af Medicine, 1935; ratating internship at Cincinnati General Haspital, 1935-36 assistant resident in Medicine, Cincinnati General Haspital, 1936-37; resident, Hamilton Caunty Tuberculasis Haspital, 1937-39; Army Medical Carps, 1939-46; resident in Pathalagy in cambined duty at Dunham Haspital and Cincinnati General Haspital; certified, American Baard af Internal Medicine, 1947; consultant in chest diseases at Cincinnati Veterans Administratian Haspitol; associate clinical prafessor af medicine, Callege af Medicine, University af Cincinnati.

GARRETT PIPKIN, M.D.
Kansas City, Mo.



Senior cansultant an arthapaedic surgery, Kansas City General Haspital; associate prafessor af surgery, Kansas University Medical Center; graduate, Washington University Schaal af Medicine, St. Lauis, 1930, with M.D. degree; served during World War II as chief af arthapaedic surgery at the Army-Navy General Haspital, Hat Springs, Arkansas, and chief af arthapaedics with the 110th Evc. Haspital; farmer directar af arthapaedic surgery, Kansas City Generol Haspital; member af Audia-Visual Cammittee af the American Acedemy af Orthapaedic Surgeans, American Callege af Surgeans, American Rheumatism Assaciatian, Saciety Internatianal Orthapaedic et' Traumatalagy.

Athletic Injuries, Their Diagnosis, Prevention and Treatment

First Christian Church, Room #43

2:00 "Injuries to Upper and Lower Extremities"
O. B. Murphy, M.D., Lexington

3:00 "Relation of the Coach, Trainer and Physician"
George M. Gumbert, Jr., M.D., Lexington

(The program will incorporate the use of slides, demonstrations, and discussion by a well-known athletic trainer).

WEDNESDAY, SEPTEMBER 20

SECOND SCIENTIFIC SESSION

COLUMBIA AUDITORIUM

Foster D. Coleman, M.D., Louisville, vice president (Central District), presiding

9:00 "Abdominal Injuries"
Charles G. Child, III, M.D., Ann Arbor, Mich.

9:20 Movie—"Hickory Chuck"
Garrett Pipkin, M.D., Kansas City, Mo.

9:40 "Emergency Airways"
Lt. Col. George F. Rumer, Ft. Sam Houston, Texas

10:00 Visit Exhibits

10:30 "The Medical Aspects of Chest Trauma"
Virgil A. Plessinger, M.D., Cincinnati, Ohio

10:50 Panel on Trauma
Alston Callahan, M.D., Birmingham, Ala.
Garrett Pipkin, M.D., Kansas City, Mo.
Virgil A. Plessinger, M.D., Cincinnati, Ohio
Jerome F. Wiot, M.D., Cincinnati, Ohio
Charles G. Child, III, M.D., Ann Arbor, Mich.

President's Luncheon

BALLROOM—BROWN HOTEL

11:50 A.M.

Richard G. Elliott, M.D., Lexington, presiding

Invocation
Rev. Ted Hightower, Pastor, St. Paul Methodist Church, Louisville

Recognitions
Richard G. Elliott, M.D.

Awards Presentations
William H. Bizot, M.D., Louisville, KSMA Awards Committee Chairman

"This Too Is The Practice of Medicine"
T. C. Petersen, American Farm Bureau Federation, Chicago, Ill.

THIRD SCIENTIFIC SESSION

COLUMBIA AUDITORIUM

Wendell V. Lyon, M.D., Ashland, vice president (Eastern District), presiding

2:00 "Favus in Kentucky: The Diagnosis, Treatment, and Epidemiology" (Kodachrome demonstration)
A. B. Loveman, M.D., Louisville
Emil Kotcher, Sc.D., Louisville

2:20 "The Physician's Relation to the Practice of Pedodontics"
Pat H. Lyddan, D.M.D., Louisville

2:40 "Sight Saving Measures for General Practitioners"
Alston Callahan, M.D., Birmingham, Ala.

3:00 Visit Exhibits

3:30 "Laboratory Diagnosis of Infectious Mononucleosis"
Walter A. Ricker, M.D., Seattle, Wash.

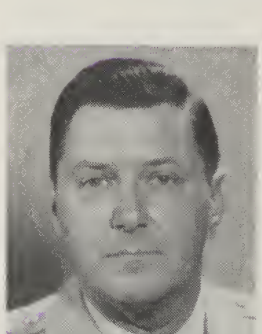
3:50 Scientific Film—"External Cardiac Massage"

CHARLES G. CHILD, III, M.D.
Ann Arbor, Mich.



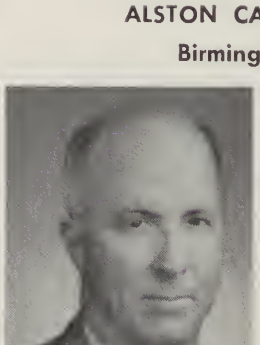
Professor and chairman of the department of surgery, University of Michigan Medical School; graduate, Cornell University Medical College, with M.D. degree in 1934; internship and residency, The New York Hospital; former associate professor clinical surgery, Cornell University; former professor of surgery and chairman of the department, Tufts University School of Medicine; member, American College of Surgeons, (Board of Governors, 1958); member, American Surgical Association; member, Society of Clinical Surgery; member, Society of University Surgeons; chairman, 1959 Institute on Clinical Teaching, Association of American Medical Colleges; director, first (Tufts) Surgical Service, Boston City Hospital, 1954-8.

LT. COL. GEORGE F. RUMER
Fort Sam Houston, Tex.



Director, department of military medicine and surgery, Army Medical Service School, Fort Sam Houston, Tex.; graduate, Jefferson Medical College with M.D. degree, 1943; internship and residency, St. Joseph's Hospital; St. Louis; former assistant chief, general surgery, Lettermon General Hospital; chief, surgical service, Fort Devens, Mass.; Diplomate, American Board of Surgery, 1956; Fellow, American College of Surgeons, 1958; Fellow, American College of Chest Physicians, 1958; received Bronze Star and Commendation ribbon with metal pendant; served in Japan and Korea; special interest in general and thoracic surgery and the role of the medical profession in civil defense.

ALSTON CALLAHAN, M.D.
Birmingham, Ala.



President of the Eye Foundation, Birmingham; member of the staffs of Carraway Methodist Hospital and University Hospital; graduate of Tulane University School of Medicine, 1933, with M.D. degree; internship, Charity Hospital, New Orleans; residency in ophthalmology, also at Charity Hospital; former private practice in Vicksburg, Miss., and Atlanta, Ga.; member American Academy of Ophthalmology and Otology, Association for Research in Ophthalmology; served in U.S. Army 1943-46, chief of eye section, Northington General Hospital, Tuscaloosa, Ala., 1944-46, discharged with rank of captain.

THURSDAY, SEPTEMBER 21

SPECIALTY GROUP MEETINGS

Seven specialty groups will meet simultaneously on Thursday morning and there will be no general session. Programs will be held in the First Christian Church, the First Unitarian Church, and Columbia Auditorium.

Sessions will run from 9:30 to 11:30 with time to visit exhibits before lunch. All members are welcome to attend any of these sessions.

Kentucky EENT Society

First Christian Church, Room #42

9:00 **"Problems in Management of the Severe Maxilio-Facial Injury"**
Earl W. Christensen, M.D., Lexington

9:30 **"Newer Concepts of Plastic Ophthalmic Surgery"**
Alston Callahan, M.D., Birmingham, Ala.

10:00 **"The Differential Diagnosis of Neck Tumors"**
Bruce Proctor, M.D., Detroit, Mich.

10:30 **"Hyaloid Phenoma Following Intra-Capsular Cataract Extraction"**
C. Dwight Townes, M.D., Louisville

Kentucky Chapter, American Academy of General Practice

Main Assembly Room, Columbia Auditorium

9:30 **"Concepts of Cerebral Vascular Accidents"**
Ephraim Roseman, M.D., Louisville

10:00 **"Office Treatment of Ano-Rectal Disease"**
James Barron, M.D., Detroit, Mich.

10:30 **Visit Exhibits**

11:00 **"Medical Self-Help, the Physician—the Public"**
1) "The General Program of the Division of Health Mobilization"
Jerrold M. Michael, M.D., Washington, D. C.
2) "The Medical Self-Help Training Kit and Training Program"
James D. Clark. M.D., Atlanta, Ga.
3) "The Physician and His Leadership Role"
Carroll L. Witten, M.D., Louisville

Kentucky Industrial Medicine Association

First Christian Church, Room #46

9:30 **Discussion Seminar on Occupational Medical Problems**
Frank Princi, M.D., Cincinnati, Moderator

Kentucky Society of Pathologists

First Christian Church, Room #44

9:30 **"Milker's Nodules"**
Ullin W. Leavell, M.D., Lexington
H. Davis Chipps, M.D., Lexington

9:45 **"Practical Application of Serum Protein Electrophoresis"**
Edward J. Fadell, M.D., Louisville

10:00 **"Familial Occurrence of the Dubin-Johnson Syndrome"**
Matthew C. Darnell, Jr., M.D., Lexington
James T. McClellan, M.D., Lexington
William P. Wharton, M.D., Lexington

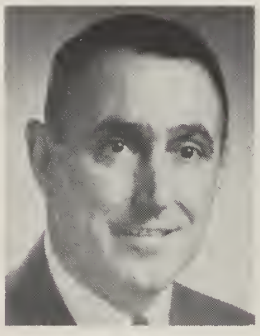
10:15 **"Diseases of the Spinal Cord"**
Ryland P. Byrd, M.D., Jeffersonville, Ind.

10:30 **"The Diagnosis of Hodgkins Disease and Lymphosarcoma by Bone Marrow Aspiration"**
Duane N. Tweeddale, M.D., Madisonville

10:45 **"Eggshell Cranium"**
Rudolph J. Muelling, Jr., M.D., Lexington

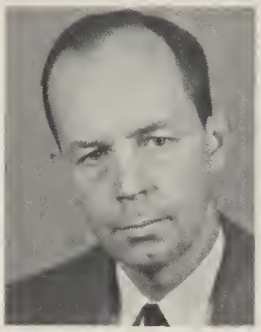
11:00 **"Quality Control in the Laboratory"**
Walter A. Ricker, M.D., Seattle, Wash.

WALTER A. RICKER, M.D.
Seattle, Wash.



Clinicol ossociate professor of pothology, University of Washington, School of Medicine; grodvote, Morquette University School of Medicine with M.D. degree, 1939; rototing internship and junior residence in pothology, Milwaukee Caunty Hospitol; consultont, pathology, U.S. Navol Hospital, Bremerton, Wosh.; consultont, hemotology, U.S. Public Service Hospitol, Seottle; pothologist, Moynord Hospitol, Seottle; certified, American Boord of Pathology, Pothologic Anotomy ond Clinicol Pathology; member, Americon Society of Clinicol Pothologists; College of Americon Pothologists; Commonding officer, 115th Medicol Bottalion, 40th Infontry Div., World War II; spacialty, morphologicol hematology ond pothology.

JAMES BARRON, M.D.
Detroit, Mich.



Surgeon-in-chorge of Division III, Henry Ford Hospital, Detroit, Mich.; groduote of Tulane University School of Medicine, New Orleans, Lo., 1940; with Henry Ford Hospitol since 1940; certified by Americon Baord of Surgery; member af Americon College of Surgeons; main surgicol interests hove been in the abdomen, especiolly concerning nutrition, stomoch, colan ond rectum; he hos published opproximately 45 or 50 medical popers. The tube feeding progrom which he will discuss hos been in extensive use ot the Henry Ford Hospitol for the post ten yeors.

FRANK PRINCI, M.D.
Cincinnati, Ohio



Associote Medciol Director, the Ethyl Corporotion, ond Associote Director, Kettering Loboratory, Cincinnoti; professor of industriol medicine, University of Cincinnoti College of Medicine; M.D. degree from University of Colorodo School af Medicine, 1941; groduote troining os Rockefeller Fellow in Industriol Hygiene ond Generol Medicine, ond ot Trudeau Sonotorium, Department of Clinicol Physiology; speciol consultont in industriol medicine to Los Alomos Scientific Loboratory; consultont to the surgeon generol, U. S. Army; diplomote, Americon Boord of Preventive Medicine; fellow, Americon Collage of Physicions; fellow ond post president of Americon Acodemy of Occupotional Medicine; fellow, Industriol Medicol Association.

Kentucky Chapter, American College of Physicians

Breaux Hall, First Unitarian Church

9:30 **"Three Unusual Cases of Hypertension Found in a Small Town Practice"**
O. T. Davis, M.D., Hopkinsville

10:00 **"Abraham Lincoln—A Medical Appraisal"**
Abraham M. Gordon, M.D., Louisville

10:30 **"Progress at the University of Louisville School of Medicine"**
J. Murray Kinsman, M.D., Louisville

11:00 **"Staphylococcal Meningitis With Subarachnoid Block, Report of a Case Successfully Treated by Infrathecal Varidase"**
H. B. McWhorter, M.D., Ashland

Kentucky Psychiatric Association

First Christian Church, Choir Room

9:30 **"Current Status of Child Welfare Program in Kentucky"**
Richard J. Clendenen, Frankfort

10:00 **"To Dream or Not to Dream"**
Louis J. West, M.D., Oklahoma City, Okla.

10:30 **"Follow-up Study of Kentucky Narcotic Addicts (Preliminary Report)"**
John A. O'Donnell, Ph.D., Lexington

11:00 **"Recent Developments in the Kentucky Mental Health Program"**
Harold L. McPheeters, M.D., Louisville

Kentucky Public Health Physicians

First Christian Church, Room #43

9:30 **"Preventive Medicine in Disaster"**
Lt. Col. George F. Rumer, Ft. Sam Houston, Texas

10:00 **Question and Answer Period**

10:30 **"The Private Practitioner in the Tuberculosis Program"**
Kurt Deuschle, M.D., Lexington

11:00 **Question and Answer Period**

FOURTH SCIENTIFIC SESSION

COLUMBIA AUDITORIUM

James T. Gilbert, M.D., Bowling Green, vice president (Western District), presiding

2:00 **"Hypnosis in Medical Practice"**
Louis J. West, M.D., Oklahoma City, Okla.

2:20 **"Nutrition in Medicine"**
James Barron, M.D., Detroit, Mich.

2:40 **"Gout"**
Brig. Gen. Robert S. Blount, Washington, D.C.

3:00 **Visit Exhibits**

3:30 **"Clinical Toxicology"**
Frank Princi, M.D., Cincinnati, Ohio
Panel on "Clinical Toxicology"
Rudolph J. Muelling, M.D., Lexington, Moderator
Richard Greathouse, M.D., Louisville
Frank Princi, M.D., Cincinnati, Ohio
Arthur J. Shulthise, M.D., Louisville

5:00 **Adjournment**

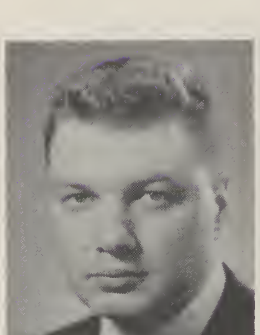
KSMA members and guests are urged to wear their badges at all times while attending the 1961 Annual Meeting.

BRIG. GEN. ROBERT E. BLOUNT
Washington, D.C.



Director of professional service, Office of the Surgeon General, Walter Reed General Hospitol; graduote, Tulane University School of Medicine, with M.D. degree, cum laude, 1932; Army Medical Service School, 1935; former, chief, deportment of medicine, Brooke Generol Hospital; received Army Commendation Ribbon and Legion of Merit; Fellow, American College of Physicians; Diplomate, American Board of Internal Medicine; member, National Boord of Medical Examiners (representing Army surgeon general); author of numerous articles in military journals and coauthor, NATO War Surgery Handbook; special interests, tropical medicine, infectious diseases, and metabolic disorders.

LOUIS J. WEST, M.D.
Oklahoma City, Okla.



Professor and head of deportment of psychiotry, neurology and behovioral sciences, University of Oklahoma, School of Medicine; graduate, University of Minnesota, Medicol School, with M.D. degree, 1949; internship, University of Minnesota Hospitols; psychiatric residency, Payne Whitney Clinic, New York Hospitol; consultant in psychiatry, Oklahoma City Veterans Hospital; research coordinator, Oklahoma Alcoholism association; chief, behovioral sciences, Oklahoma Medical Research Foundation; national consultant in psychiatry to surgeon general U.S.A.F.; advisory editor, Internationol Journol of Clinicol and Experimental Hypnosis; Fellow, Americon Psychiatric Association; certified in psychiatry, American Board of Psychiatry and Neurology, 1954; diplomote, National Board of Medical Examiners, 1949.

Insert Photo Discontinued

The Annual Meeting issue of The Journal in August 1960 was the last to carry the insert-photograph of the incoming president of KSMA. It was decided by the Advisory Committee to the Editor at a meeting two years ago to discontinue this feature. It was pointed out that the insert is actually a duplication since a large photograph of the retiring president appears in each Annual Meeting issue.

Cocktail Party Planned

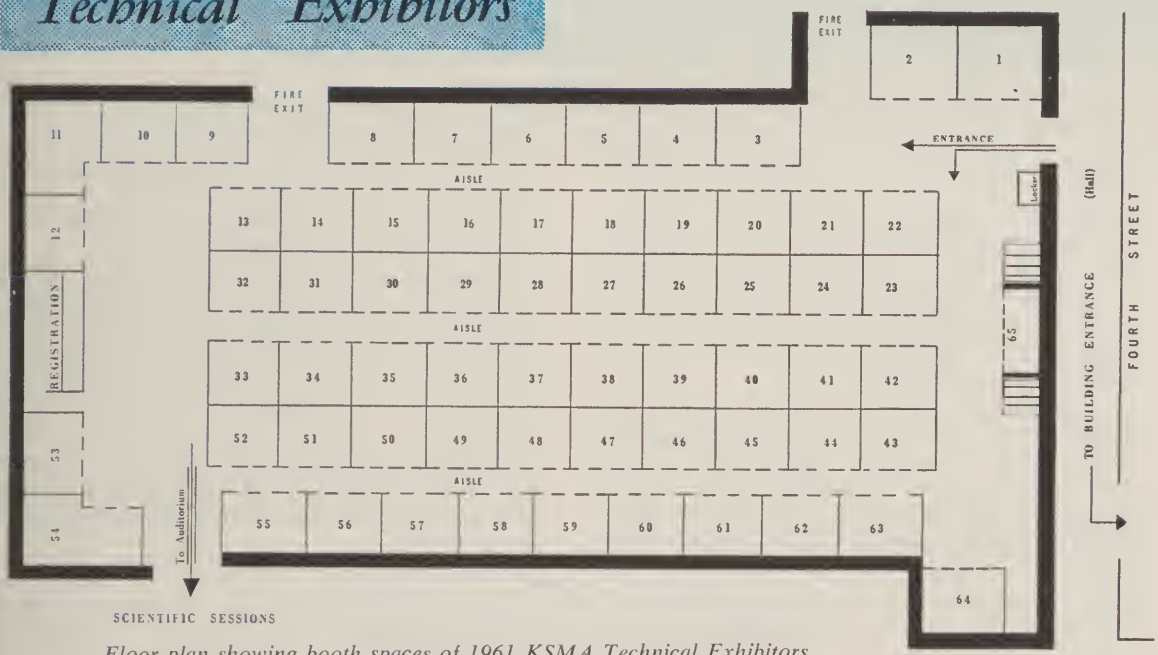
A cocktail party is tentatively planned by an interested medical group to be held in conjunction with other Annual Meeting activities. Present plans, according to Hoyt D. Gardner, M.D., Louisville, chairman of the group, are for the hour before the appearance of Edward R. Annis, M.D., Miami, Fla. Doctor Annis will speak on "Medical Aid For the Aged" in the Flag Room of the Kentucky Hotel at 8 p.m. on Thursday, September 21.

Scientific Exhibitors

(Located to the right of main entrance)

1. **Medical and Biological Illustrations**
   University of Kentucky Chapter of Biological Photographic Association, W. L. Cooper, M.D., Lexington
2. **Carcinoma of the Major Hepatic Ducts—An Unsolved Problem**
   George B. Sanders, M.D., Louisville
3. **The Aging Skin**
   Committee on Cosmetics, American Medical Association, Chicago
4. **Single Adenoma of the Thyroid (Surgical Approach and Pathology of)**
   D. Maurice Royalty, M.D., and H. Davis Chipps, M.D., Lexington
5. **Milker's Nodules**
   Ullin W. Leavell, M.D., and H. Davis Chipps, M.D., Lexington
6. **Chemotherapy of Cancer**
   Raymond J. Krause, M.D.; Charles D. Hofner, M.D.; Edward S. Strasser, M.D.; and John J. Cranley, M.D., Cincinnati
7. **Sunlight and the Skin**
   Committee on Cosmetics, American Medical Association, Chicago
8. **Salvage of Limbs by Small Artery Anastonosis**
   Alvin B. Ortner, M.D.; Harold F. Berg, M.D.; Alvin Lebendiger, M.D.; and Harold E. Kleinert, M.D., Louisville
9. **Exhibits on Factors Relating to Highway Safety**
   KSMA Committee on Highway Safety and Kentucky State Department of Police
10. **The Use of the Operating Microscope in Vascular Surgery**
    Benjamin B. Jackson, M.D., Louisville
11. **The Chronic Draining Ear**
    Thomas E. Booth, M.D., Louisville
12. **University of Louisville, Department of Ophthalmology —Lions Eye Bank**
    Roderick McDonald, Jr., M.D., Louisville

Technical Exhibitors



Floor plan showing booth spaces of 1961 KSMA Technical Exhibitors

Abbot Laboratories (23)
A. S. Aloe Company (63)
Ames Company, Inc. (4)
Ayerst Laboratories (57)
Baker Laboratories (61)
Blue Cross (27)
Borcherdt Company (41)
Burton Parsons & Co. (48)
Burroughs Wellcome & Co. (52)
Ciba Pharmaceutical Products (18)
Coca-Cola Company (64)
Crocker Fels Company (15)
Desitin Chemical Company (36)
Dictaphone Corporation (46)
Doho Chemical Company (37)
Eaton Laboratories (10)
Encyclopaedia Britannica (5)
Geigy Pharmaceuticals (35)
Gerber Baby Foods (58)
Guild of Prescription Opticians (39)
John Hancock (65)
Johnson & Johnson (9)
Kay Surgical, Inc. (11)
Lederle Laboratories (1)
Eli Lilly & Company (32)
J. B. Lippincott Company (59)
Logan Company (8)
McNeil Laboratories, Inc. (7)
J. A. Majors Company (2)
Malkin Instrument Company (47)
Maltbie Laboratories Division (16)
Mead Johnson Laboratories (3)
Medco Products Company (6)
Medical Protective Company (19)
Merck Sharp & Dohme (42)
Miller Surgical Company (24)
C. V. Mosby Company (49)
Ortho Pharmaceutical Corp. (14)
Parke, Davis & Company (33)
Pfizer Laboratories (40)
Polythress & Company, Inc. (56)
R. J. Reynolds (38)
A. H. Robins Company, Inc. (21)
Roche Laboratories (12)
William H. Rorer, Inc. (45)
Ross Laboratories (26)
Sandoz Pharmaceuticals (31)
Schering Corporation (22)
Julius Schmid, Inc. (29)
Clayton L. Scroggins (53)
G. D. Searle & Company (55)
Smith, Kline & French (44)
Smith, Miller & Patch (28)
E. R. Squibb & Sons (20)
Theodore Tafel (30)
United States Tobacco Company (17)
Upjohn Company (51)
U. S. Vitamin & Pharmaceutical Corp. (54)
Van Pelt & Brown, Inc. (34)
Wampole Laboratories (60)
Warner-Chilcott Laboratories (43)
Warren-Teed Products Company (25)
Westwood Pharmaceuticals (62)
Winthrop Laboratories (13)
Max Wocher & Son Company (50)

This year's KSMGA tournament will be held at the Standard Country Club on Old Brownsboro Road, September 19-21.



Site of KSMGA Golf Tourney

1961 Golf Tourney To Be Held At Standard Country Club

Standard Country Club on Old Brownsboro Road, about two miles east of its junction with U. S. 42, will be the site of the annual golf tourney of the KSMGA from September 19-21.

Announcement of this year's tourney, a traditional adjunct to the Annual Meeting, was made by Edwin P. Solomon, Jr., M.D., chairman of the golf committee. The "host plan" will be in operation and members of the committee will be present to greet golfers on their arrival at the Club.

This year the permanent prizes to the three top winners will be purchased at the Standard Country Club pro shop and may be exchanged for anything of like value. These permanent prizes, plus one year's possession of traveling trophies will be awarded to those winning top honors in the low gross, low net, and senior championship categories.

Last year top prizes went to D. M. Royalty, M.D., Lexington, low gross; Merle W. Fowler, Jr., M.D., Paducah, low net; and Thomas J. Overstreet, M.D., Lexington, senior championship.

Members of the Associate Committee on KSMA Golf headed by Doctor Solomon, include: James Archer, M.D., Paintsville; Harold Baker, M.D., Louisville; Clifton G. Follis, M.D., Glasgow; Martin Kaplan, M.D., Kenton D. Leatherman, M.D., Lanier Lukins, M.D., and William C. Wolfe, MD., all of Louisville.

Golfers wishing to play should send the attached application blank to the KSMA headquarters office enclosing the $6 in dues which includes both dues and green fees.

CLIP HERE

APPLICATION FOR MEMBERSHIP
KSMA Golf Association

(Please complete and return immediately)

to: KSMA Golf Committee
Kentucky State Medical Association
1169 Eastern Parkway
Louisville 17, Kentucky

Name .....

Street .....

Town .....

Cash enclosed is $6.00 ..... **Check, $6.00** .....

During the 1961 annual KSMA Golf Tournament, I would like to play September 19, 20 or 21. (Circle day or dates)

PROGRAM

THIRTY-NINTH ANNUAL MEETING
WOMAN'S AUXILIARY
TO THE
KENTUCKY STATE MEDICAL ASSOCIATION

BROWN HOTEL
LOUISVILLE, KENTUCKY
September 19, 20, 21, 1961

REGISTRATION:
North Bay of Lobby, Brown Hotel
Monday 12 noon to 5 p.m.
Tuesday 8 a.m. to 5 p.m.
Wednesday 9 a.m. to 11 a.m.

MONDAY, SEPTEMBER 18

3:30 P.M.

Finance Committee Meeting

TUESDAY, SEPTEMBER 19

8:45 A.M.

PARLORS A B C, BROWN HOTEL

Pre-convention Board Breakfast (subscription). All state officers, councilors, state committee chairmen, county auxiliary presidents, and the three immediate past presidents are urged to attend.

10:30 A.M.

SOUTH ROOM

Formal opening of the 39th Annual Convention of the Woman's Auxiliary to the Kentucky State Medical Association.

Presiding ..... Mrs. Earl W. Roles
Louisville, President

Invocation ..... Mrs. John Y. Barbee
Bowling Green, Third Vice President

Pledge of Allegiance to the Flag ... Mrs. Paul F. Rizk
Grayson

"I pledge allegiance to the flag of the United States of America and to the Republic for which it stands. One Nation, under God, indivisible, with liberty and justice for all."

Pledge of Loyalty ..... Mrs. J. Andrew Bowen
Louisville

"I pledge my loyalty and devotion to the Woman's Auxiliary to the American Medical Association. I will support its activities, protect its reputation and ever sustain its high ideals."

Address of Welcome ..... Mrs. Hugh P. Adkins
Louisville
President—Jefferson County Auxiliary

Response ..... Mrs. William C. Roland
Ashland
President—Boyd-Carter-Greenup County Auxiliary

Presentation of Distinguished Guests

Adoption of Convention Rules ..... Mrs. Oris Aaron
Columbia, Parliamentarian

Presentation of Convention Chairman Mrs. Harry Pfingst
Louisville

Roll Call ..... Mrs. John B. Floyd, Jr.
Lexington, Recording Secretary

Minutes of the 38th Annual Convention ..... Mrs. John B. Floyd, Jr.

Report of the 1961 National Convention
Mrs. Victor P. Dalo
Louisville

Report of the Councilor of the Woman's Auxiliary to the Southern Medical Association
Mrs. Charles B. Johnson
Russell
Councilor from Kentucky

President's Address ..... Mrs. Earl W. Roles
Prospect

REPORT OF OFFICERS:

President-elect ..... Mrs. Guy Morford
Owensboro

Treasurer ..... Mrs. R. O. C. Green
Bowling Green

Corresponding Secretary .... Mrs. Thomas E. Booth
Louisville

Report of Registration ..... Mrs. P. J. Murphy
Lebanon Junction

REPORTS OF CHAIRMEN:

A. M. E. F. ..... Mrs. Melvin Bernhard
Louisville

Benevolence ..... Mrs. Raymond Sanders
Williamsburg

Cancer ..... Mrs. William Wharton
Lexington

Health Careers ..... Mrs. George A. Buckmaster
Henderson

Legislation ..... Mrs. F. H. Hodges
Pikeville

McDowell House ..... Mrs. Walker Owens
Mt. Vernon

Mrs. James Rich
Lexington

Parliamentarian ..... Mrs. Oris Aaron
Columbia

Nominating Committee .... Mrs. Charles B. Johnson
Russell

Presentation of the 1961-62 Budget
Mrs. Carlisle Morse
Louisville, Finance Chairman

Old Business:
Resolutions: Cancer Program, Health Careers, Policy Sheet, McDowell House Catalogue

New Business.

Election of Nominating Committee for 1961-62

"Policy and Practice" Viewed by State Chairmen—
Moderator ..... Mrs. Robert C. Long
Louisville, Program Chairman

Participants:
Mrs. William G. Clouse, Richmond—Civil Defense
Mrs. J. Murray Kinsman, Louisville—Rehabilitation
Mrs. Charles Rutledge, Hazard—Heart
Mrs. Charles D. Clark, Murray—Mental Health
Mrs. W. H. Wainer, Providence—Rural Health
Mrs. C. Dana Snyder, Hazard—Coordination of Members-at-Large
Mrs. Sam D. Taylor, Henderson—Tuberculosis

In Memoriam ..... Mrs. William R. Cartmell
Maysville, Councilor District 9

12:30 P.M.
SOUTH ROOM
SUBSCRIPTION LUNCHEON

Honoring
Past Presidents and Distinguished Guests

Invocation ..... Mrs. Charles Kissinger
Owensboro, Councilor District 2

Address ..... Mrs. Kalford Howard
Portsmouth, Va.
President, Woman's Auxiliary to the Southern Medical Association

2:00 P.M.
SOUTH ROOM

Address ..... Gaithel L. Simpson, M.D.
KSMA President-elect

Report of County Auxiliary Presidents
Program ..... Mrs. Robert C. Long
Louisville

3:30-5:00 P.M.

TEA

Honoring Distinguished Guests
Home of Mrs. Burford Davis, 2 Woodhill Road

WEDNESDAY, SEPTEMBER 20

9:30 A.M.
SOUTH ROOM

Invocation ..... Mrs. R. E. Davis
South Carrollton, Councilor District 3

Roll Call ..... Mrs. John B. Floyd, Jr.
Lexington

Reading of Minutes ..... Mrs. John B. Floyd, Jr.

Presentation of Distinguished Guests

Announcements ..... Mrs. Harry A. Pfingst
Convention Chairman

Address ..... Richard G. Elliott, M.D.
KSMA President

Presentation of Health Citation Award
Mrs. G. B. Forage
Paducah, Community Service

Response

Address ..... Mrs. William G. Thuss
Birmingham, Ala.

Election of Officers

Presentation of Gavel ..... Mrs. Earl W. Roles

Inaugural Address ..... Mrs. Guy Morford
Owensboro

Final Report of Registration ..... Mrs. P. J. Murphy

Courtesy Resolutions ..... Mrs. J. M. Dishman
Greensburg, Councilor District 4

12:30 P.M.
KENTUCKY HOTEL
TERRACE ROOM

SUBSCRIPTION LUNCHEON AND STYLE SHOW

In Honor Of
Mrs. William G. Thuss, President-elect
Woman's Auxiliary to the
American Medical Association

Invocation ..... Mrs. E. T. Smith
Somerset

Presentation of Distinguished Guests

Presentation of Past Presidents

Presentation of Officers

Style Show Commentator ... Mrs. William Golden Davis

Adjournment

THURSDAY, SEPTEMBER 21

8:45 A.M.
SOUTH ROOM

Post-Convention Board Breakfast (subscription)

Presiding ..... Mrs. Guy Morford
Owensboro

Invocation ..... Mrs. Robert J. Salisbury
Mt. Sterling

Meeting of Membership Committee

STATE CONVENTION COMMITTEE

General Chairman ..... Mrs. Harry A. Pfingst
Louisville

Registration ..... Mrs. P. J. Murphy
Lebanon Junction

Decorations—Flowers ..... Mrs. Louis Mitzlaff
Mrs. Arthur Kasey
Mrs. Houston Shaw
Louisville

Luncheon ..... Mrs. John Gordinier
Mrs. Rhodes Burnam
Louisville
Finance ..... Mrs. Robert Nolan
Louisville
Publicity ..... Mrs. Marvin A. Lucas, Louisville
Official Hostesses ... Mrs. Robert Monroe, Louisville
Mrs. Charles B. Johnson, Russell
Mrs. William R. Gabbert, Owensboro
Mrs. James T. Ramsey, Frankfort
Tellers ..... Mrs. Proctor Eubank, Louisville
Mrs. James Ryan, Louisville
Time Keeper .. Mrs. James E. Williams, Nicholasville
Exhibits ..... Mrs. Meyer Harrison, Louisville
Pages ..... Mrs. Walter Coe, Louisville
Mrs. J. Ray Bryant, Louisville
Mrs. William G. Clouse, Richmond
Mrs. Vernon Pace, Paducah
Tickets ..... Mrs. William C. Durham, Louisville
Tickets for Wednesday Style Show
Mrs. David M. Cox, Louisville
Mrs. Robertson O. Joplin, Louisville

STATE OFFICERS
1960-1961

President ..... Mrs. Earl W. Roles, Prospect
President-elect ..... Mrs. Guy Morford, Owensboro
First Vice President .Mrs. Hugh Mahaffey, Richmond
Second Vice President ...Mrs. C. I. Haeberle, Russell
Third Vice President
Mrs. John Y. Barbee, Bowling Green
Fourth Vice President ..... Mrs. Keith Smith, Corbin
Recording Secretary
Mrs. John B. Floyd, Jr., Lexington
Corresponding Secretary
Mrs. Thomas E. Booth, Louisville
Treasurer ..... Mrs. R. O. C. Green, Bowling Green
Parliamentarian .... Mrs. Oris Aaron, Elizabethtown

ADVISORY COMMITTEE

John A. Bishop, M.D., Jeffersontown
L. O. Toomey, M.D., Bowling Green
Joe M Bush, M.D., Mt. Sterling

IMMEDIATE PAST PRESIDENTS

Mrs J. Andrew Bowen, Louisville
Mrs. Jess T. Funk, Bowling Green
Mrs. Charles B. Johnson, Russell

DISTRICT COUNCILORS

1st—Mrs. Hugh L. Houston, Murray
2nd—Mrs. Charles C. Kissinger, Henderson
3rd—Mrs. R. E. Davis, South Carrollton
4th—Mrs. J. M. Dishman, Greensburg
5th—Mrs. Harold Graves, Louisville
6th—Mrs. J. Jack Martin, Tompkinsville
7th—Mrs. Harry J. Cowherd, Frankfort
8th—Mrs. C. Walker Air, Ludlow
9th—Mrs. William H. Cartmell, Maysville
10th—Mrs. James S. Williams, Nicholasville
11th—Mrs. Robert J. Salisbury, Mt. Sterling
12th—Mrs. Barton L. Ramsey, Jr., Somerset
13th—Mrs. J. W. Bailey, Ashland
14th—Mrs. George P. Archer, Prestonsburg
15th—Mrs. Garrett Croft, Harlan
Coordinator for Members-at-Large—Mrs. C. Dana Snyder, Hazard

COMMITTEE CHAIRMEN

American Medical Education Foundation
Mrs. C. Melvin Bernhard, Louisville
Benevolence ...Mrs. Raymond Sanders, Williamsburg
Blue Grass News, Editor
Mrs. J. Andrew Bowen, Louisville
co-Editor
Mrs. Marvin A. Lucas, Louisville
Bulletin ..... Mrs. Jess T. Funk, Bowling Green
By-Laws and Parliamentarian
Mrs. Oris Aaron, Columbia
Cancer ..... Mrs. William Wharton, Lexington
Civil Defense .... Mrs. William G. Clouse, Richmond
Community Service .....Mrs. G. B. Forage, Paducah
Doctor's Shop ....Mrs. Carroll P. Price, Harrodsburg
Finance ..... Mrs. Carlisle Morse, Louisville
Health Careers
Mrs. George A. Buckmaster, Henderson
Heart ..... Mrs. Charles Rutledge, Hazard
Historian ..... Mrs. A. B. Colley, Owensboro
Legislation ..... Mrs. F. H. Hodges, Pikeville
McDowell House .... Mrs. Walker Owens, Mt. Vernon
Mental Health ..... Mrs. Charles P. Clark, Murray
Nominations ..... Mrs. Charles B. Johnson, Russell
Past-President ..... Mrs. P. E. Blackerly, Louisville
co-chairman—Mrs. Victor P. Dalo, Louisville
Program ..... Mrs. Robert C. Long, Louisville
Rehabilitation ....Mrs. J. Murray Kinsman, Louisville
Rural Health ....Mrs. William H. Wainer, Providence
Safety .....Mrs. Clyde Brassfield, Elizabethtown
Tuberculosis ..... Mrs. Sam D. Taylor, Henderson

PAST PRESIDENTS

*1923—Mrs. Graham Lawrence, Shelbyville
*1924—Mrs. Graham Lawrence, Shelbyville
*1925—Mrs. Van Albert Stilley, Benton
*1926—Mrs. Van Albert Stilley, Benton
*1927—Mrs. William M. Martin, Harlan
*1928—Mrs. James Thomas Reddick, Paducah
1929—Mrs. P. E. Blackerly, Louisville
1930—Mrs. E. B. Houston, Murray
*1931—Mrs. George A. Hendon, Louisville
1932—Mrs. Arthur T. McCormack, Louisville
*1933—Mrs. Bartlett K. Menefee, Covington
*1934—Mrs. Joseph L. Greenwell, New Haven
1935—Mrs. Luther Bach, Florence
*1936—Mrs. Ernest Arthur Barnes, Albany
1937—Mrs. Stephen C. McCoy, Louisville
*1938—Mrs. Harlan Usher, Sedalia
1939—Mrs. Reasor T. Layman, Elizabethtown
1940—Mrs. John M. Blades, Butler
*1941—Mrs. John G. South, Frankfort
1942—Mrs. John B. Floyd, Richmond
1943—Mrs. Octavus Dulaney, Louisville
*1944—Mrs. Eleanor Hume Offutt, Frankfort
1945—Mrs. Shelby Carr, Richmond
1946—Mrs. Elmer L. Henderson, Louisville
1947—Mrs. Walker Owens, Mt. Vernon
1948—Mrs. R. Haynes Barr, Owensboro
1949—Mrs. Elbert W. Jackson, Paducah
1950—Mrs. Clark Bailey, Harlan
1951—Mrs. John S. Harter, Louisville
1952—Mrs. David Woolfolk Barrow, Lexington
1953—Mrs. Clyde C. Sparks, Ashland
1954—Mrs. Karl D. Winter, Louisville
1955—Mrs. R. Ward Bushart, Fulton
1956—Mrs. Charles B. Stacy, Pineville
1957—Mrs. J. Andrew Bowen, Louisville
1958—Mrs. Jess T. Funk, Bowling Green
1959—Mrs. Charles B. Johnson, Russell

*Deceased

EDITORIALS

What Is The Truth About Drug Prices ?

PHYSICIANS were not exempt from sharing the general confusion attending the Kefauver drug hearings. The witnesses presented views so extreme and opinionated to make them of little help in establishing a reasonable understanding. According to Senator Kefauver, his two years of work uncovered evidence of exaggerated advertizing of new drugs, unacceptable promotional activities and a lack of competition in the industry leading to high costs. He has, therefore, introduced the following legislation to correct these flaws: limitation of patent rights to three years, insistence on generic name prescribing, and licensure of manufacturers who will be under constant investigation.

Senator Kefauver is but one problem confronting the drug industry. Their greatest concern is a medical one—productive lines of research. This is the lifeline of their business. Only one product in 2,865 research trials will produce a marketable substance. Once discovered, it must be proven, submitted for government approval, put into production, distributed and reach the market before competitor products. If it is to be profitable, it must be a truly new product and not merely molecule manipulation of old ones.

In addition to this, international trade has brought foreign products to the corner drug store. Competition was intensified further when proprietary houses invaded the ethical field. Approaching the physician with products has become more involved since the number of detail men and mailing devices have reached the point of diminishing returns.

Senator Kefauver proved only one point conclusively: some advertising procedures were unwise. Other than this, the drug industry may claim no unique features but resembles other large businesses in all respects. The one concrete result from the investigation so far has been to complicate detailing procedures and thereby increase expenses without any real benefit being obtained. Evidently the senator is a strong advocate of private enterprise so long as it is under rigid government control.

Undoubtedly the drug investigations have been of greatest value to the designers of the welfare state who have limitless governmental financing to carry on a perpetual propaganda program for free medical services. Our most recent reward from governmental agencies for providing the best medical care and drug research in history has been a manifest contempt for the positive programs put forth by the medical associations even reaching the point of spending tax funds to establish cultist "hospitals." If we tolerate such niggardly treatment, we deserve the consequences.

Homer B. Martin, M. D.

For Your Information and Profit

MORE than 55 speakers of national and Kentucky renown will be heard by Kentucky physicians at the KSMA Annual Meeting in Louisville, September 19, 20, and 21.

General practitioners and specialists in many fields will find the program designed to add to their scientific knowledge generally and specifically. You can follow the progress and scientific developments made by the entire field of medicine and you can hear the latest and best scientific information concerning your own specialty.

Guest speakers from across the nation will be presented at the four general scientific sessions at Columbia Auditorium. Many top-notch Kentucky scientists will also participate in the three-day meeting. Some of these same speakers and many others will take part in the fourteen specialty group meetings to be held Tuesday afternoon and Thursday morning. All physicians are welcome to attend as many of the specialty group sessions as desired.

To see the latest in medications, methods, instruments, books and periodicals, visit the technical and commercial exhibitors. These exhibitors help defray costs and make this wonderfully educational and informative meeting possible.

Also at the meeting you may observe the policy-making House of Delegates in action on Monday and Wednesday nights. Matters of importance to the medical profession will be sent to Reference Committees which will meet on Tuesday afternoon. You may attend these meetings and be heard by the committees if you so desire. This is your opportunity to make your opinion count on matters of concern to you. This is also your opportunity to meet all KSMA officers.

On the lighter side of things, check to see if your medical school graduating class is one of the reunion classes meeting this year in conjunction with the Annual Meeting. And bring along your golf clubs and play in the KSMGA golf tournament.

You'll find these information-filled three days profitable to you as you discover new methods and techniques for treating your patients. As a matter of fact, where could a Kentucky physician spend a more informative and profitable three days with such pleasant company as his friends and colleagues in Kentucky medicine?

George W. Pedigo, M.D.

Be sure to attend the two non-scientific features of the KSMA Annual Meeting—

- T. C. Petersen will speak at the President's Luncheon, at the Brown Hotel on Wednesday, September 20. His topic will be, "This Too Is The Practice of Medicine."

- Edward R. Annis, M.D., will speak on "Medical Care For the Aged" at 8 p.m. on Thursday, September 21, in the Flag Room of the Kentucky Hotel.

ORGANIZATION SECTION

Over-65 Group Offered New Coverage By Blue Plans

Blue Cross-Blue Shield is offering new coverage to the over-65 age group. Beginning September 1, eligible Direct Pay and Farm Bureau subscribers, regardless of age, will be given an opportunity to apply for higher benefits. The offer will be made at a due date of their present contract and the entire program will take 12 months to complete due to the variation in subscribers' billing dates.

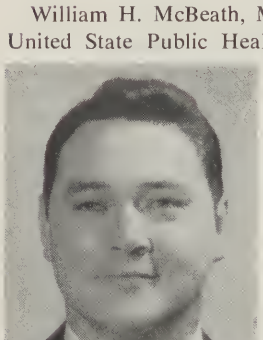
Under this program, members of Blue Cross only may apply to increase their room allowance up to $15 per day, and add either Standard or Preferred Blue Shield with Endorsements. Members who have both Blue Cross and Standard Blue Shield may apply to increase their room allowance up to $15 per day and change to Preferred Blue Shield with Endorsements.

More than 250,000 members are now enrolled in Kentucky Blue Cross-Blue Shield on a direct pay basis. This opportunity will enable them to voluntarily prepay or budget in advance for more care. If rejected, for health reasons, present benefits of the member will not be affected.

As of June 30, 1961, there were 716,137 Blue Shield members in Kentucky and 805,687 Blue Cross members.

Dr. McBeath To Serve On Medical Care Program

William H. McBeath, M.D., a career officer of the United State Public Health Service, will be medical administrator of Kentucky's new Medical Care Program in connection with his new post as acting director of the Division of Medical Care.



William H. McBeath, M.D.

Other duties connected with his Kentucky assignment as community health resident include work with the Kentucky State Department of Health and the Department of Community Medicine, College of Medicine, University of Kentucky.

Doctor McBeath, a native of Leitchfield, received his B.S. degree from Georgetown College in 1953, and his M.D. degree from the University of Louisville School of Medicine in 1957. He served with the United States Air Force as a flight surgeon and preventive medicine officer after a rotating internship at Jefferson Davis Hospital, Houston.

He succeeds Patricia Conlan Nicol, M.D., who resigned the first of June after her marriage to Alan Nicol, M.D., a physician with the United States Public Health Service leper hospital at Carville, La.

Teaching Hospital Will Open Soon At U of K

The University of Kentucky's new 500-plus bed teaching hospital will begin to accept patients around the first of next year, the exact date depending on final construction schedules, ordering of equipment and assignment of the staff. Much of the equipment is already on order, with estimates of the total equipment cost for the hospital at about two million dollars.

Facilities in the new hospital are included for general medicine and surgery, pediatrics (including premature infants), psychiatry, obstetrics, and rehabilitation. Some 120 examining rooms provide space for all of the clinical services and specialties of the Outpatient unit. The Emergency Service also occupies its own facility and will have available five examining rooms and two treatment rooms.

Admission to University Hospital will be by referral of the patient's private physician, and on the order of a member of the Medical Staff, each of whom will also be a member of the faculty of the College of Medicine. It is anticipated that a major portion of the patients admitted to the inpatient service will first be seen as out-patients.

Assuming adequate financial support, it is expected that patients from all economic categories—indigent, part pay, and full pay—will be eligible for admission on an equal basis. Payment for services will be scaled to the amount of personal or third-party resources available to the patient. By means of the referral process, physicians throughout the Commonwealth should find University Hospital readily accessible to all patients whom they feel would benefit from the broad range of services which will be available.

It is expected that the first Inpatient area to be activated will be a 65-bed general medical and surgical unit, a portion of which will be temporarily equipped for the care of pediatric patients. This will permit the admission of all types of patients with the exception of obstetrics, premature infants, long-term rehabilitation and certain categories within psychiatry.

AMA Meeting Attended By 111 Kentucky Physicians

One hundred and eleven Kentucky physicians are known to have registered at the Annual Meeting of the American Medical Association in New York, June 25-30. Lloyd Prang, director of membership of the AMA has provided The Journal with this information. A total of 23,000 physicians attended the meeting.

Kentucky's official representatives to the House of Delegates were W. Vinson Pierce, M.D., Covington; Robert C. Long, M.D., Louisville; and George F. Brockman, M.D., Greenville. Other official representatives of the KSMA were Richard G. Elliott, M.D., Lexington, KSMA president; Gaithel L. Simpson, M.D., Greenville, president-elect; J. Vernon Pace, M.D., Paducah and John Quertermous, M.D., Murray, both alternate delegates to the AMA.

The complete list of Kentucky physicians in attendance follows:

BARLOW

H. G. Sargent, M.D.

BOWLING GREEN

Frederick Eberson, M.D.
Guthrie Y. Graves, M.D.

CAMPELLSVILLE

W. E. Atkinson, MD.

CARROLLTON

James O. Mattax, M.D.

CLINTON

V. A. Jackson, M.D.

COVINGTON

Elmer E. DeVillez, M.D.
Wellington Vernon Lee, M.D.
W. Vinson Pierce, M.D.
Douglas W. McKay, M.D.

DANVILLE

Charles W. Caldwell, Jr., M.D.

GREENVILLE

George F. Brockman, M.D.
Gaithel L. Simpson, M.D.

HARLAN

William H. Anderson, M.D.
A. C. Hohn, M.D.
Herman K. Schueler, M.D.
R. Burke Suitt, M.D.

HENDERSON

Millard R. Shaw, M.D.

LEXINGTON

Richard G. Elliott, M.D.
G. M. Gumbert, Jr., M.D.
Lloyd O. Larsen, M.D.
Champ Ligon, M.D.
Graydon A. Long, M.D.
Edward H. Ray, M.D.
Edward H. Ray, Jr., M.D.
C. I. Schwartz, M,D.
William R. Willard, M.D.
William K. Massie, Jr., M.D.

LOUISVILLE

John T. Bate, M.D.
Oren A. Beatty, M.D.
Armand E. Cohen, M.D.
Henry S. Collier, M.D.
M. R. Cronen, M.D.
Elbert L. Dennis, M.D.
Clyde H. Foshee, M.D.
H. D. Gardner, M.D.
J. Thomas Giannini, M.D.
Laman A. Gray, M.D.
D. P. Hall, M.D.
J. Duffy Hancock, M.D.
Douglas Haynes, M.D.
John C. Hill, M.D.
Arthur T. Hurst, M.D.
Benjamin B. Jackson, M.D.
J. Murray Kinsman, M.D.
Zollman Kommor, M.D.
C. D. LeNeave, M.D.
Nathan Levene, M.D.
Robert Lich, Jr., M.D.
Robert C. Long, M.D.
R. W. Lykins, M.D.
Homer B. Martin, M.D.
A. Clayton McCarty, M.D.
G. David McClure, M.D.
Milton F. Miller, M.D.
William C. Mitchell, M.D.
Robert F. Monroe, M.D.
Carlisle Morse, M.D.
David Neustadt, M.D.
James E. Parker, M.D.
Irving B. Perlstein, M.D.
Frank Pirkey, M.D.
Forest F. Radcliff, M.D.
Gradie R. Rowntree, M.D.
Marjorie Rowntree, M.D.
William T. Rumage, M.D.
Charles B. Severs, M.D.
A. A. Shaper, M.D.
Edward C. Shrader, M.D.
Marjorie K. Smith, M.D.
L. H. South, M.D.
Donald L. Ware, M.D.
J. F. Williamson, M.D.
Carroll L. Witten, M.D.

MAYSVILLE

Harry C. Denham, M.D.

MIDDLESBORO

P. L. Fuson, M.D.

MILLWOOD

A. L. Embry, M.D.

MOREHEAD

S. E. Reynolds, M.D.

MT. STERLING

Frank K. Sewell, M.D.

MURRAY

Hugh L. Houston, M.D.
John Quertermous, M.D.

OWENSBORO

Guy Morford, M.D.
Sara Jean Parks, M.D.
Merrill W. Schell, M.D.
Frank L. Yarbrough, M.D.
H. B. Pendleton, M.D.

PADUCAH

Charles B. Billington, M.D.
J. Vernon Pace, M.D.

PIKEVILLE

A. G. Osborne

PRESTONSBURG

Russell L. Hall, M.D.

RUSSELL

Charles B. Johnson, M.D.

SCOTTSVILLE

Earl P. Oliver, M.D.

STURGIS

Wallas N. Bell, M.D.

SOMERSET

Morris Holtzclaw, MD.

AMA Registration (Continued)

OF UNDETERMINED LOCATION

A. Bashirelachi, M.D.
Thomas Davis, M.D.
David D. Drye, M.D.
G. Ertugrul, M.D.
David R. Jacobs, M.D.
Robert J. T. Joy, M.D.
Martin L. Garno, M.D.
Suat Koro, M.D.
Justin MacCarthy, M.D.
F. A. Martin, Jr., M.D.
Maurice Nataro, M.D.
B. Nedelkoff, M.D.
Cavit Ozlu, M.D.
Alex Saliba, M.D.
Walter P. Savage, M.D.
Daniel Stowens, M.D.
Nguyen Van Nho, M.D.

Dr. Simpson Is Conservation Leader In Muhlenberg Area

According to the Division of Soil and Water Resources of the Department of Conservation, Gaithel L. Simpson, M.D., Greenville, KSMA president-elect, is also a leader in the conservation of the natural resources in his area of the state. His interest in conservation has brought to him the chairmanship of the East Fork Pond River Watershed Conservancy District in Muhlenberg, Christian and Todd Counties.

Through his leadership the farmers and others in the watershed area have developed a plan to increase conservation farming and alleviate many of the flood problems in the watershed.

On his 1,250-acre farm in southwestern Muhlenberg County, Doctor Simpson has constructed four farm ponds, built three miles of drainage ditch, tile drained nearly 500 acres, terraced 150 acres, constructed 20 acres of sod waterways, planted 27,000 trees, and has established several wildlife plantings.



Doctor Simpson looks over some of the 25,000 pine trees that were planted as a soil and water conservation measure on his Muhlenberg County farm.

Dr. Lawson, With UL 29 Years, Dies At 57

Hampden Clisby Lawson, M.D., professor and chairman of the department of physiology at the University of Louisville School of Medicine for 29 years, died of cancer at his home in Louisville on June 23.



Hampden C. Lawson, M.D.

Doctor Lawson, 57, was active in research on muscular activity of the alimentary tract, blood flow through the intestine, hemorrhage, shock, blood substitutes, blood volume, and cardiac output.

A native of Arkansas, he held a Ph. D. degree from the University of Chicago and received his medical degree from the University of Louisville in 1938. He was assistant in biochemistry at the University of Arkansas from 1928 to 1930, and an assistant in physiology at the University of Chicago where he was also a Donnelley Fellow in 1930-32. He joined the U. of L. Medical School faculty in 1932 as an assistant professor of physiology and became chairman of the department in 1941. From 1948 to 1952 he also served as director of the school's Institute for Medical Research.

A member of the AMA, KSMA, and Jefferson County Medical Society, Doctor Lawson also belonged to the Southern Society for Clinical Research, the Louisville Medico-Chirurgical Society, and the American Physiological Society.

Dr. McCarty Takes On Two New Offices

A. Clayton McCarty, M.D., Louisville, who has long been active in medical-organization affairs, won two offices at recent meeting in New York. As president-elect of the American Geriatrics Society, he was installed as president at a meeting of that group. He was also elected first vice-president of the American Therapeutic Society.

Doctor McCarty retired from a busy practice of internal medicine after a heart attack in 1959. But he has continued his organizational activities. He is due to assume the presidency of the Southern Medical Association next year.

He has also headed the Jefferson County Medical Society and has been a vice president of the KSMA. He chaired the first committees on aging of both groups and has been a leader in numerous other medical affairs.

A $5,000 gift from the Louisville Foundation has helped the cardiovascular laboratory of General Hospital to purchase a $17,000 fluoroscope to replace an old one that had been giving off dangerous amounts of radiation.

The Weeders, Van Gogh, Bernard Koehler Collection, Berlin



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Essential in moving external masses, but potentially dangerous in moving the bowels, since vascular accidents may be precipitated in heart patients by excessive straining at stool. For cardiac patients with constipation, Metamucil adds a soft, bland bulk to the bowel contents to stimulate normal peristalsis and also to hold water within stools to keep them soft and easy to pass. Thus Metamucil, with an adequate water intake, induces natural elimination with a minimum of straining. Metamucil also promotes regularity through "smooth-age" in all types of constipation.

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SEARLE



Dr. Fister



Dr. Larson

AMA Elects Dr. Fister Installs Dr. Larson

George M. Fister, M.D., Ogden, Utah, was chosen president-elect of the American Medical Association at its 110th Annual Meeting in New York City, June 29.

Leonard W. Larson, M.D., 62, a pathologist from Bismarck, N. D., was installed as president. Doctor Larson was a member of the AMA's policy-making House of Delegates from 1940 to 1959, and has served on the AMA Board of Trustees since 1960. He succeeds E. Vincent Askey, M.D., 64, a Los Angeles surgeon.

A specialist in urology, Doctor Fister has served as a member of the AMA Board of Trustees since 1957 and was previously a member of the House of Delegates. He is currently serving as director and member of the Utah Division of the American Cancer Society, National Association of Blue Shield Plans, National Affairs Committee of the Ogden Chamber of Commerce and is a member of the Medical Advisory Staff of Ship Hope.

Doctor Fister is a past president of the Utah State Medical Association, and of the Western Section of the American Urological Asociation. He has been clinical lecturer in surgery in the University of Utah College of Medcine for several years, is now serving on the Board of Regents of that university and is a member of the board's medical college advisory committee. He has been one of the principal backers of

Film Produced by HEW, AMA To Assist Physicians

"The Disability Decision" is the title of a movie which has been produced by the Department of Health, Education and Welfare in cooperation with the American Medical Association to assist physicians in examining and reporting patients for possible disability claims from the Social Security Administration.

The KSMA Council on Communications and Public Service has reviewed the film and has recommended it as possible program material for meetings of County Medical Societies.

The film may be obtained from Hugh A. McNary, Jr., District Manager of the Social Security Administration Office in Louisville, 620 South Third Street, or from any of the Social Security District offices located at: Ashland, Bowling Green, Corbin, Covington, Frankfort, Hazard, Hopkinsville, Lexington, Owensboro, Paducah, or Pikeville.

UK Class of 1965 Set For Entrance in September

The 1965 graduating class of the University of Kentucky College of Medicine, to enter the school in September, 1961, will be the second class for the new Medical School. The class is made up of 55 men and four women; 48, or over 80 per cent, are from the state of Kentucky.

Class members range in age from 20 years to 35 years, with a mean age of 23.3. The number married is 18, and unmarried, 41. The first class began with 18 married students, and only 22 single.

Twenty-seven counties of Kentucky are represented in the new class. The largest number of students is from Jefferson County (11), with Fayette County second (8).

Class members are from more than 40 different colleges and universities. The University of Kentucky has contributed the largest number—17. There are five from Western Kentucky State College and four from the University of Louisville.

Names of those entering the freshman class in September 1961 (1965 graduating class) follow:

B. Russell Allen, McHenry, Ky.
Raleigh R. Archer, Prestonsburg, Ky.
Theodore M. Beck, Brooklyn, New York
Henry S. Beeler, Jr., Lebanon Junction, Ky.
Benjamin S. Bell, Elkton, Ky.
Henry R. Bell, Jr., Elkton, Ky.
James D. Blanding, Jr., Lexington, Ky.
C. Dale Brown, Clay, Ky.
Ronald K. Burke, Springfield, Mass.
Bobby C. Campbell, Clinton, Ky.
Robert M. Carey, Lexington, Ky.
Perry B. Clark, Louisville, Ky.
Frederick G. Cox, Jonancy, Ky.
William W. Creech, Lexington, Ky.
Francis M. Criswell, Hitchins, Ky.
Victor J. DiOrio, Jr., Louisville, Ky.
Eugene H. Eisman, Miami Beach, Fla.
James H. Fuller, Bardwell, Ky.
Roseanne C. Glick, Covington, Ky.
Stanley L. Greenbaum, Brooklyn, N. Y.
William M. Hall, Salyersville, Ky.
Thomas E. Hamilton, Vanceburg, Ky.
John William Hare, Evansville, Ind.
Joe Michael Hazel, Barberton, Ohio
Clyde L. Holloway, Middletown, Ky.
Noah William Klein, Harrison, N. Y.
Shirley Ann Lewis, Lexington, Ky.
Edward A. Luce, Florence, Ky.
Donald T. McAllister, Louisville, Ky.
John R. McClane, Louisville, Ky.
James R. McMahon, Louisville, Ky.
Franklin D. Master, Louisville, Ky.
Shirley Ann Moore, Louisville, Ky.
William M. Morton, Newport, Ky.
Kelly Gene Moss, Glasgow, Ky.
Leonard W. Mulbry, New Smyrna Beach, Fla.
Richard Lee Munich, Lexington, Ky.
James R. O'Rourke, Jr., Lexington, Ky.
James A. Parrott, Corbin, Ky.
Gerald L. Points, III, Dry Ridge, Ky.
Allan H. Pribble, Covington, Ky.
Darrell E. Rains, Williamsburg, Ky.
Benjamin A. Reid, Louisville, Ky.
Herman R. Reno, Jr., Paducah, Ky.
Billy Gray Roberts, Murray, Ky.
Jimmy Don Robinson, Kevil, Ky.
Robert Lee Rold, Owensboro, Ky.
Paul G. Rossano, New Orleans, La.
Lucy Ruth Salmon, Madisonville, Ky.
Sidney R. Steinberg, Lexington, Ky.
Gerald F. Sturgeon, Louisville, Ky.
Ziad Abu-Khaled Tamimi, Hebron, Jordan
Ed Waggener, Columbia, Ky.
William H. Wagner, Middlesboro, Ky.
William R. Walters, Jr., Toledo, Ohio
Raymond D. Wells, Lancer, Ky.
Charles O. Wilson, Jr., Ashland, Ky.
Alfred Byron Young, Somerset, Ky.
James John Zilis, Louisville, Ky.

the university medical center.

The 111th Annual Meeting of the AMA will take place in Chicago in 1962, at which time Doctor Fister will be inaugurated as the 116th president of the Association.

Congressman-MD Judd Receives Distinguished Service Award

Rep. Walter H. Judd (R., Minn.), a former medical missionary, received the American Medical Association's 1961 Distinguished Service Award at the opening of the Association's Annual Meeting. Rep. Judd was named for his noted achievements as a medical missionary, humanitarian and statesman devoted to world peace.

A member of Congress since 1942, Rep. Judd was author of World Health Organization and the International Children's Fund legislation. He had previously served at various Chinese posts as a medical missionary for the Congregational Foreign Mission Board.

The award, a medal and citation, has been given annually since 1938. It is presented to a physician who has made a notable contribution to the advancement of medical science. Nominations for the award are made by the association membership at large, studied by the Board of Trustees and passed on to the House of Delegates which makes the final selection of the recipient.

U of L Trustees Approve New Appointments

At a meeting of the University of Louisville trustees on June 21, the following School of Medicine appointments were approved: George Randolph Schrodt, M.D., assistant professor of pathology; Warren Cox, M.D., instructor in psychiatry; Alvin A. Peters, M.D., research associate in the department of pharmacology; Ji-Toong Ling, MD., acting-chairman of the department of radiology during the illness of Everett L. Pirkey, M.D.; Warren S. Rehm, M.D., acting-chairman of the department of physiology during the illness of Hampden Lawson, M.D.

Promotions were: Herbert C. Pirkle, M.D., from assistant to associate professor of pathology; Everett G. Grantham, M.D., from acting-chief of the neurosurgery section to chief; and Roderick MacDonald, M.D., from assistant to associate professor of ophthalmology.

The resignations of A. Clayton McCarty, M.D., and John M. Townsend, M.D., were accepted. J. P. Holt, M.D., professor of medicine, was given the additional appointment of associate in the biology department of the graduate school in the College of Arts and Sciences.

On the same day, a report titled "Ten Years of Growth" as issued by Dr. Philip Davidson, president of the University. In it he says that a university hospital and a medical-dental education building are among projects included in a 10-year development program already under way. The medical-dental building has very high priority in the U. of L.'s construction plans according to Woodrow M. Strickler, executive vice president.

In an article in the Louisville Times, Mr. Strickler

NOTE

To County Society Secretaries and Members

Annual AMA dues will be increased $10 on January 1, 1962, and an additional $10 on January 1, 1963, following action by the AMA House of Delegates in New York, June 26. When this increase becomes effective, the annual dues for active members will be $35 a year in 1962 and $45 in 1963. This is the first AMA dues increase in 12 years.



The AMA Annual Meeting June 25-30, was definitely long on LONGS, all Rebels. Left to right: Arkansas alternate Delegate C. C. Long, Kentucky delegate Robert C. Long, Louisiana delegate Arthur D. Long, and Mississippi State Medical Association president Lawrence W. Long gather outside the AMA House of Delegates in the Statler Hilton, New York City.

also commented on an education bill now in Congress which has a matching fund provision for medical and dental schools. He said the University would become active right away, should the bill pass, to take advantage of the Federal aid. Passage of the bill would give the University a reason to try to raise funds, he added.

The medical-dental building, proposed for the Medical Center, was the principal item in the $7,000,000 U. of L. bond issue which was defeated by voters last year.

Other news from the U. of L. School of Medicine includes a $40,900 grant from the National Science Foundation to Calvin A. Lang, M.D., assistant professor of biochemistry, who will study cellular respiration in animals and how this process changes in relations to the animals' growth state.

Dr. Mullen, Mr. Ruskjer Take New Posts As Waverly Closes

The last patients at Waverly Hills Tuberculosis Sanatorium were transferred to Hazelwood Sanitorium on June 1 and the Louisville-Jefferson County hospital was officially closed. Renovations were completed at Hazelwood sooner than was expected, so the final closing came two weeks earlier than was planned last year when the State decided to take over care of TB victims in Louisville and Jefferson County. Plans for future use of Waverly Hills are indefinite.

Alvin B. Mullen, M.D., medical director of the hospital until its closing, will take on new duties July 1 as announced by Thomas S. Wallace, Jr., M.D., acting-director of the Louisville-Jefferson County Health Department. Doctor Mullen will succeed Doctor Wallace as City-County Tuberculosis Control Officer and Director of the TB clinic.

Waverly's hospital administrator, S. A. Ruskjer, announces that a number of employees have gone to Hazelwood and others went to General Hospital. Mr. Ruskjer will become director of hospital administration for the Kentucky-Tennessee Conference of Seventh Day Adventists on July 1. He will continue as consultant in hospital administration to the State Tuberculosis Hospital Commission.

Dr. Gardner on AMA Program

The AMA Institute, to be held August 31-September 1 in Chicago, will have a Kentucky physician, Hoyt D. Gardner, M.D., Louisville, on its program. The insitute is designed to brief medical society leaders on all of medicine's current action programs.

Doctor Gardner will discuss the course he teaches at the U. of L. School of Medicine covering medical civics and ethics. This is one of four such projects now conducted in the nation's medical schools. He will speak on Thursday afternoon, August 31.

Charles K. Sergeant, M.D., a native of Beaumont, Texas, has begun the practice of pediatric surgery in connection with the Department of Surgery of the University of Louisville School of Medicine. He received his medical degree from Johns Hopkins University in 1954 and took his internship and residency at Henry Ford Hospital, Detroit. He had previously served as a captain with the Army Air Force.

Salk Vaccine Distributed By Health Department

The Kentucky State Department of Health has announced that it has distributed enough Salk polio vaccine since January to provide 346,500 shots. The vaccine has been sent to local health departments throughout the State in an effort to forestall a possible polio epidemic here this summer.

Epidemics have occurred in the South already this year, notably in Atlanta, Georgia. Traditionally, the infectious season moves northward, usually reaching a peak in Kentucky the latter part of July and the first part of August.

Between January to July of this year, 16 cases were reported to the Department. In 1960, one of the worst polio years in Kentucky since the Salk vaccine became available, 146 cases—127 of them paralytic—were reported. Kentucky was one of only seven states to show an increase in polio last year, the others being Idaho, Maryland, Montana, North Carolina, Rhode Island, and Wyoming.

"With the Salk polio vaccine readily available throughout the State, it is folly for people not to take advantage of the protection it offers," said Edwin H. West, M.D., Director of the Department's Bureau of Local Health. The new oral vaccine will not be available for distribution in Kentucky this season, he added.

Millard C. Loy, M.D., Columbia, was recognized as the Kiwanis Club's Outstanding Citizen of 1961 at a meeting in Columbia on June 27.

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Bottle of 50.

Dosage: 1 tablet t.i.d. at mealtime and 2 at bedtime.

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Thiamine Mononitrate	10 mg.
Riboflavin	10 mg.
Niacinamide	100 mg.
Vitamin C	200 mg.
Pyridoxine Hydrochloride	5 mg.
Calcium Pantothenate	20 mg.
Vitamin B_{12}	5 mcg.

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"nutrition...present as a modifying or complicating factor in nearly every illness or disease state"[1]

1. Youmans, J. B.: Am. J. Med. 25:659 (Nov.) 1958

cardiac diseases "Who can say, for example, whether the patient chronically ill with myocardial failure may not have a poorer myocardium because of a moderate deficiency in the vitamin B-complex? Something is known of the relationship of vitamin C to the intercellular ground substance and repair of tissues. One may speculate upon the effects of a deficiency of this vitamin, short of scurvy, upon the tissues in chronic disease."[2] 2. Kampmeier, R. H.: Am. J. Med. 25:662 (Nov.) 1958.

arthritis "It is our practice to prescribe a multiple vitamin preparation to patients with rheumatoid arthritis simply to insure nutritional adequacy . . ."[3]
3. Fernandez-Herlihy, L: Lahey Clinic Bull. 11:12 (July-Sept.) 1958.

digestive diseases Symptoms attributable to B-vitamin deficiency are commonly observed in patients on peptic ulcer diets.[4] Daily administration of therapeutic vitamins to patients with hepatitis and cirrhosis is recommended by the National Research Council.[5] 4. Sebrell, W. H.: Am. J. Med. 25:673 (Nov.) 1958. 5. Pollack, H., and Halpern, S. L.: Therapeutic Nutrition, National Academy of Sciences and National Research Council, Washington, D. C., 1952, p. 57.

degenerative diseases "Studies by Wexberg, Jolliffe and others have indicated that many of the symptoms attributed in the past to senility or to cerebral arteriosclerosis seem to respond with remarkable speed to the administration of vitamins, particularly niacin and ascorbic acid. These facts indicate that the vitamin reserve of aging persons is lowered, even to the danger point, more than is the case in the average American adult."[6] 6. Overholser, W., and Fong, T.C.C. In Stieglitz, E. J.: Geriatric Medicine, 3rd edition, J. B. Lippincott, Philadelphia, 1954, p. 264.

infectious diseases Infections cause a lowering of ascorbic acid levels in the plasma; and the absorption of this vitamin is reduced in diarrheal states.[7] 7. Goldsmith, G A.: Conference on Vitamin C. The New York Academy of Sciences, New York City, Oct. 7 and 8, 1960. Reported in: Medical Science 8:772 (Dec.10) 1960.

diabetes Diabetics, like all patients on restricted diets, require an extra source of vitamins.[8] "Rigidly limiting the bread intake of the diabetic patient automatically eliminates a large amount of thiamin from the diet. . . . There is some evidence of interference with normal riboflavin utilization during catabolic episodes."[9]
8. Duncan G. G.: Diseases of Metabolism 4th edition W. B. Saunders, Philadelphia, 1959, p. 812. 9. Pollack, H.: Am. J. Med. 25:708 (Nov.) 1958.

FOR FULL INFORMATION SEE YOUR SQUIBB PRODUCT REFERENCE OR PRODUCT BRIEF.

Two KAGP Seminars Held In July

The Big Sandy Seminar of the Kentucky Academy of General Practice was held at the Paintsville Country Club on July 6. The Chairman was John W. Turner, M.D., Paintsville, and co-chairmen were Ralph W. Allen, M.D., Pikeville, and Glenn R. Powell, M.D., also of Paintsville.

Those participating in the scientific session were: J. Thomas Giannini, M.D., Louisville; Harvey Chenault, M.D., Lexington; Daniel E. Mahaffey, M.D., and David H. Dorton, Jr., M.D., both of Louisville.

Attendance was expected to reach 100 at the Symposium on Vacation Mishaps held by the KAGP at the Kentucky Dam Village, Gilbertsville, on July 20. Moderator of the Symposium was Thornton Bryan, Jr., M.D., Cadiz.

Others participating in the program were: William D. Paul, M.D., head of the Gastoscopic Clinic, Professor of Medicine and Rehabilitation, and Supervisor of varsity athletics, State University of Iowa, College of Medicine, Iowa City, Iowa; Edgar B. Morton, M.D., Louisville; E. Newton Hesbacher, M.D., dermatologist with the George F. Geisinger Memorial Hospital and the Foss Clinic, Danville, Penn.; and Donald R. Germann, M.D., Associate Professor of Radiology, University of Kansas School of Medicine, Kansas City, Kansas.

Dr. Van Besien To Head Clinic of VA Office

George J. Van Besien, M.D., has been appointed director of the outpatient clinic of the Veterans Administration regional office, Louisville. A native of Iowa, Doctor Van Besien has been serving as director of professional services in the outpatient clinic of the Kansas City regional V. A. office.

He received his medical degree from St. Louis University and was in private practice in Decorah, Iowa, before entering the Army Medical Corps in War War II.

Doctor Van Besien succeeds Oliver P. Miller, M.D., who has retired, and who now resides at Columbia, Ky.

Lexington Clinic Sets Fall Clinical Conference

The Sixth Annual Fall Clinical Conference sponsored by the Lexington Clinic and the Kentucky Academy of General Practice will be held in Lexington on October 27. Plans for the Conference include a number of outstanding guest speakers.

The complete program for the meeting, which has been approved for six hours of Category I Credit by the AAGP, will appear in the September issue of The Journal.

Some of the speakers on the program will be: Wesley Farnsley, M.D., Louisville, vice president of the Kentucky Division of the American Cancer Society; Michael J. Brennan, M.D., Division of Oncology, Henry Ford Hospital, Detroit, Mich.; John Githens, M.D., professor of pediatrics, University of Kentucky College of Medicine; Kenneth Crispell, M.D., professor of medicine, University of Virginia; and Robert Kierland, M.D., Section of Dermatology at the Mayo Clinic, Rochester, N. Y.

Rehabilitation Center Gets Head

New medical director of the Rehabilitation Center in Louisville and acting chairman of the department of physical medicine and rehabilitation at the University of Louisville School of Medicine, is Herman Wing, M.D., a native of Boston. Doctor Wing succeeds Rex O. McMorris, M.D., in the Rehabilitation Center post. Doctor McMorris went to Peoria, Ill., last year as medical director of the Institute of Physical Medicine and Rehabilitation there.

Doctor Wing was the first person to receive both M.D. and LL.B. degrees from the University of Texas. He has previously had a general practice in Austin, Texas, where he was also medical director of the Texas Confederate Home, a chronic disease hospital. He has also practiced industrial medicine in St. Louis and for the past year has been assistant professor of physical medicine and rehabilitation at Baylor University Medical School.

Jesse W. Smth, M.D., Paris, who has been radiologist at the Bourbon County Hospital since it opened nine years ago, has resigned that position effective August 1. He left the hospital July 1 for a month's vacation prior to his formal resignation date.



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Postgraduate Opportunities Listed Through November

The Postgraduate Medical Education Office takes pleasure in announcing six Postgraduate Courses planned through November. The first, X-Ray Interpretation, is a 12 week intermittent program, being held October 5 through December 21 on Thursday evenings at Louisville General Hospital. The second is a program on Pulmonary Diseases scheduled for October 11 and 12 at the University of Kentucky Medical Center. The third offering is scheduled for October 19 in Pikeville, to be on the subject of Recent Advances in Therapeutics. Fourth is the Obstetrics & Gynecology opportunity to be held in Paducah on November 2. The fifth is an Anesthesiology course to be held at Louisville General Hospital on November 9. The sixth offering is a Clinical Neurology Postgraduate Course scheduled for November 16 at Louisville General Hospital.

Also, recently we have received the listings of the Ohio State University and the University of North Carolina, and thus have added them to our published listings.

Detailed information may be obtained from the Postgraduate Medical Education Office, 104 West Chestnut Street, Louisville 2. The telephone number is JUniper 7-7135.

The complete listing follows:

AUGUST

Weekly through 1961	One week training in the field of OB & GYN, each week during 1961, with the exception of: October 2-7, and October 23-28; limitation to two physicians per week; fee of $50 includes room at Louisville General Hospital, if desired; 42 hours of Category I Credit granted by the AAGP; enrollment should be made at least two weeks before desired participation.
16	KAGP Seminar, Cumberland Falls, Kentucky.
20	KAGP Seminar, Lexington, Kentucky.

SEPTEMBER

11-15	Eighth Annual Postgraduate Course on "Aviation Medicine," Ohio State University, Columbus 10, Ohio, Dr. William F. Ashe, Chairman of the Department of Preventive Medicine.
18-23	Postgraduate Course, "Changing Concepts of Cardio-Pulmonary Disease," Ohio State University, Columbus 10, Ohio, Dr. James V. Warren, Chairman of the Department of Medicine.
19-21	Annual Kentucky State Medical Association Meeting, Louisville.

OCTOBER

3	Postgraduate Course, "Medicine," University of North Carolina, to be held at Asheville, N. C., Afternoon and evening sessions.
4	Postgraduate Course, "Medicine," University of North Carolina, to held at Morganton, N. C., Afternoon and evening sessions.
5 - December 21	Postgraduate Course, "X-RAY INTERPRETATION," 12 week intermittent program to be held at Louisville General Hospital, Thursday evenings.
6-8	Central Associational Meeting of Obstetricians and Gynecologists, Cleveland, Ohio.
10	Postgraduate Course, "Pediatrics," University of North Carolina, to be held at Asheville, N. C., Afternoon and evening sessions.
11	Postgraduate Course, "Pediatrics," University of North Carolina, to be held at Morganton, N. C., Afternoon and evening sessions.
11-12	Postgraduate Course, PULMONARY DISEASES, University of Kentucky Medical Center, Lexington.
15	Sixth Annual Session on Rheumatic Diseases, Ohio State University, Columbus 10, Ohio. Dr. F. W. McCoy, Director of Rheumatology Division.
17	Postgraduate Course, "Surgery," University of North Carolina, to be held at Asheville, N. C., Afternoon and evening sessions.
18	Postgraduate Course, "Surgery," University of North Carolina, to be held at Morganton, N. C., Afternoon and evening sessions.
19	Postgraduate Course, RECENT ADVANCES IN THERAPEUTICS, Green Meadows Country Club, Pikeville, Kentucky.
19	KAGP Seminar, Maysville, Kentucky.
24	Potsgraduate Course, "Medicine," University of North Carolina, to be held at Asheville, N. C., Afternoon and evening sessions.
25-26	John Walker Moore Seminar, Louisville Society of Internists, Dr. Stuart Graves.
25	Postgraduate Course, "Medicine," University of North Carolina, to be held at Morganton, N. C., Afternoon and evening sessions.
25	KAGP Seminar, Mammoth Cave, Kentucky.
26	Fall Seminar at Our Lady of Peace Hospital, Louisville, Dr. Hollis Johnson.
27	Annual Fall Clinical Conference of the Lexington Clinic, to be held at the Campbell House Hotel in Lexington, Dr. John B. Selby.
30-November 24	Potgraduate Course, "Psychiatry," Ohio State University Columbus 10, Ohio, Dr. Ralph M. Patterson, Chairman of the Department of Psychiatry.
31	Postgraduate course, "Medicine," University of North Carolina, to be held at Asheville, N. C., Afternoon and evening sessions.

NOVEMBER

1	Postgraduate course, "Medicine," Univer-

	sity of North Carolina, to be held at Morganton, N. C., Afternoon and evening sessions.
2	Postgraduate course, OBSTETRICS & GYNECOLOGY, Paducah, Kentucky.
7	Postgraduate course, "Medicine" University of North Carolina, to be held at Asheville, N. C., Afternoon and evening sessions.
8	Postgraduate course, "Medicine," University of North Carolina, to be held at Morganton, N. C., Afternoon and evening sessions.
9-10	A two-day symposium to be given by the University of North Carolina at Chapel Hill, N. C., general topics have not yet been decided on at this time.
9	Postgraduate course, ANESTHESIOLOGY, Louisville General Hospital.
16	Postgraduate course, CLINICAL NEUROLOGY, Louisville General Hospital.
27-30	AMA Clinical Meeting, Denver.

A 1955 graduate of the University of Louisville School of Medicine, **S. Philip Greiver, M.D.,** has begun a practice limited to internal medicine in Louisville. Doctor Greiver interned and took one year of residency at Maimonides Hospital, Brooklyn N. Y. He served for two years as a captain in the Army at the U. S. Army Hospital, Fort MacArthur, Calif., after which he continued residency training at Barnes Hospital, St. Louis, Mo., and Louisville General Hospital.

NEWS ITEMS

Philip T. Bennett, M.D., has begun practice in Louisville in association with **John D. Gordinier, M.D.,** and **Robert C. Long, M.D.,** in a practice limited to obstetrics and gynecology. Doctor Bennett received his medical degree from the University of Texas School of Medicine in 1954 and interned at Baylor University Hospital, Dallas, Texas. He took his residency in ob-gyn at Fitzsimmons Army Hospital, Denver, Colo. He served in the U. S. Air Force for three years with the rank of captain.

Kenneth W. Dumars, Jr., M.D., a native of Denver, Colo., where he received his medical degree from the University of Colorado in 1945, has joined the staff of the University of Kentucky College of Medicine. Doctor Dumars is presently in the Department of Pathology, but will eventually be connected with the Department of Pediatrics. He interned at Minneapolis General Hospital and took his residency at the University of Colorado Medical Center. He also spent some time at the University of Wisconsin studying the cytogenetic technique of chromosomal pattern demonstration. He served two years in the Army with the rank of captain and has had a previous practice in Colorado Springs, Colo.

Carl H. Fortune, M.D., Lexington, received the honorary degree of Doctor of Science at Translyvania College commencement exercises on June 11. Doctor Fortune has chaired several KSMA committees and long been active in the Fayette County Medical Society.

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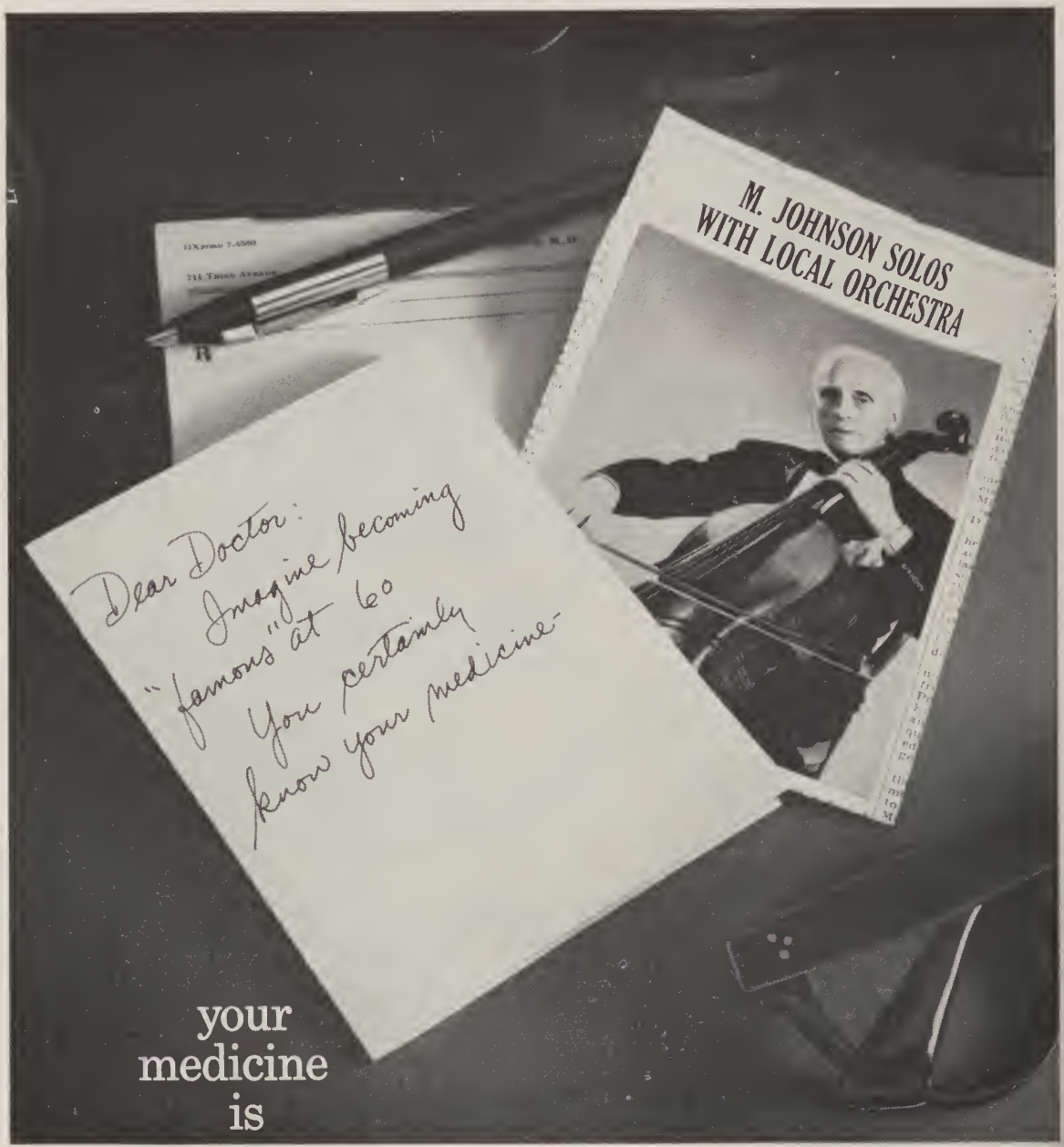
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KSMA Council, Committee Reports

KSMA Council on Aging

Earl P. Oliver, M.D., Chairman

Louisville **June 8, 1961**

The KSMA Aging Committee had as guests at its first meeting of the year A. Clayton McCarty, M.D., Louisville, Avil McKinney, Director of hospital Physicians Service, Louisville, and the Rev. H. Dix Archer, Chairman of the Citizens Commission on Aging.

The Governor's Conference on Aging held in Louisville in September of 1960 and the White House Conference on Aging were fully discussed. It was felt by the committee that the AMA had been put in bad light by the newspapers and others in charging the AMA had rigged the conference. Actually, the majority of the physicians were not in the section that voted on health care for the aged under the social security mechanism.

Following a request from Reverend Archer, the committee recommended that the KSMA endorse legislation which would put the commission on a statutory basis.

The committee noted that Blue Cross—Blue Shield will in the Fall of 1961 open a preference plan to all people regardless of age.

After a lengthy discussion on several topics, a report was formulated to be sent to the Council on Medical Services.

Building Committee

George F. Brockman, M.D., Chairman

Louisville **July 12, 1961**

Emmet F. Horine, M.D., Brooks, KSMA official historian appeared before the committee and discussed the appropriate use of old medical literature and souvenirs in the new building. Doctor Brockman expressed appreciation for Doctor Horine's willingness to work with the committee as consultant on these matters.

The architect reported that progress on the construction of the new building was satisfactory.

There was a discussion of the Metropolitan Sewer District's request for easements on KSMA property for trunkline sewage.

A preliminary discussion took place on recommendations the committee would make to the Board of Trustees of KSMA relative to negotiations for a construction loan. Preliminary plans for landscaping the grounds following construction were discussed.

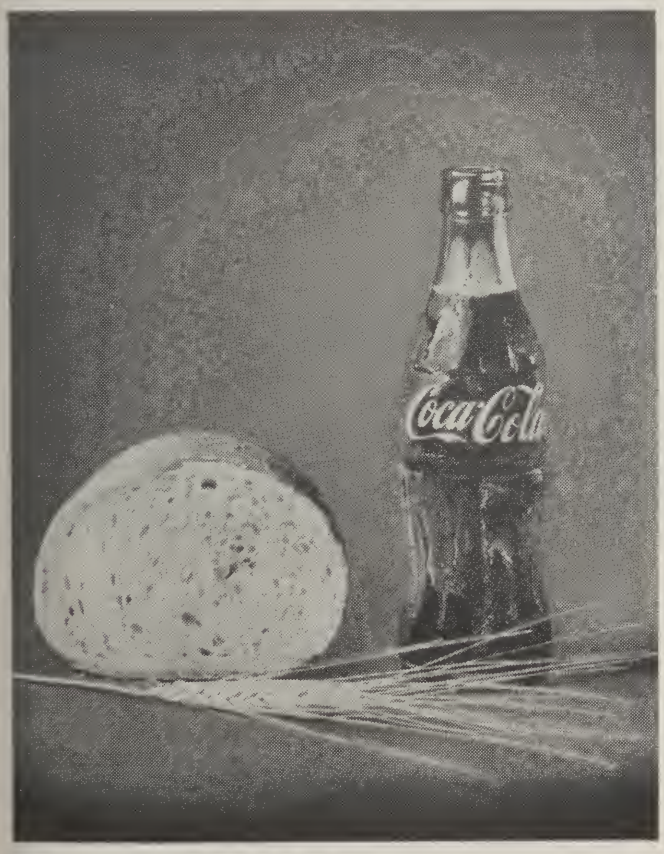
KSMA Committee on Tuberculosis

Richard E. Mardis, M.D., Chairman

Louisville **May 31, 1961**

One of the main items under discussion by the committee was the request of the 1960 House of Delegates asking that further study be given the report of the TB Committee presented to the 1960 session.

It was noted by the committee that the first Ken-



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tucky Conference on TB was held in Lexington on May 3-5, 1961, which was attended by approximately 25 persons, all experienced in TB. This conference published a report as to its findings and recommendations. Inasmuch as this report covered the areas presented by the 1960 TB Committee to the House of Delegates, it was the feeling of the committee that the report adapted at Lexington be presented to the Council on Allied Professions and Related Groups with the recommendation that this report be approved by the KSMA.

Due to the length of the report, it will not be listed here, but will be available from the KSMA headquarters office for anyone interested in reading it in its entirety.

Liaison Committee to Voluntary Health Groups

Ralph M. Denham, M.D., Chairman

Louisville **June 19, 1961**

The Committee at its first meeting of the year heard a report on the letters that had been sent to 15 national and county voluntary health organizations informing these groups that the KSMA has such a committee and that this committee stands ready to assist these groups in any way possible. It was noted that 11 replies were received in response to the letter thanking the committee for its offer.

Also, the committee discussed a resolution presented by the Tennessee State Medical Association at the June 1960 AMA Annual Meeting which pertained to a list of principles that associations could use in dealing with the National Foundation. This was accepted as information only.

Letters that had been received from the various health groups indicated that the majority have medical advisory committees at the state level and that none of these groups had asked for any assistance from the committee.

It was the feeling of the committee that physicians at the county level should be aware of the drives in their areas and that they should be alert to practices that are contrary to the sound intent of the public.

AMA Auxiliary Picks Mrs. Roles

Mrs. Earl W. Roles, Prospect, president of the Woman's Auxiliary to the Kentucky State Medical Association, has been named to the publications committee of the Woman's Auxiliary to the AMA.

Donald L. Arnett, M.D., left his practice in Mt. Vernon on June 17 to re-enter training to complete his medical specialty. Doctor Arnett is a 1958 graduate of the University of Louisville School of Medicine.

A native of Chicago and graduate of the Stritch School of Medicine of Loyola University in 1950, **Donal D. O'Sullivan, M.D.,** has joined the staff of Lourdes Hospital, Paducah, as a pathologist. Doctor O'Sullivan took his internship at Madigan Medical Hospital and his residency at Mercy Hospital, Toledo, Ohio. Before moving to Paducah, he had practiced general and industrial medicine in Chicago. He has served in the Medical Corps of the U.S. Army with the rank of major, since 1950, actively from 1950 to 1952 and as a member of the Reserves since then.

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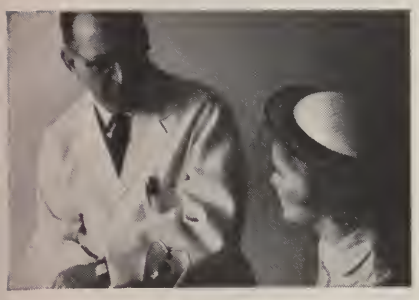
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1. Barden, F. W., et al.: J. Maine M. A. 46:99, 1955.
2. Ford, R. A., and Blanchard, K.: Journal-Lancet 78:185, 1958.

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In Memoriam

RICHARD ALEXANDER BATE, JR., M.D.
Louisville
1906-1961

A 55-year-old internist, Richard Alexander Bate, Jr., M.D., Louisville, died of a heart attack at his home on June 28. Doctor Bate, a native Louisvillian and a 1932 graduate of the University of Louisville School of Medicine had practiced internal medicine in Louisville since his graduation.

He was a past president of the Louisville Society of Medicine and was a member of the Louisville Society of Internists, Jefferson County Medical Society, AMA and KSMA.

B. EARL CAYWOOD, M.D.
Danville
1906-1961

A widely known physician who had been a resident of Danville for 22 years, B. Earl Caywood, M.D., died of a heart attack at his home July 10. Doctor Caywood was a native of Jessamine County and received his medical degree from the University of Louisville School of Medicine in 1931. He was 54.

MEINRAD J. HERL, SR., M.D.
Louisville
1883-1961

Meinrad, J. Herl, Sr., M.D., died at his home in Louisville on June 21. He was 77.

Doctor Herl graduated from the University of Kentucky Pharmacy School in 1907 and received his medical degree from the University of Louisville Medical School in the same year. He taught chemistry at the Louisville College of Pharmacy for several years and was a practicing physician in Louisville for many years.

JOHN CALVIN HART, M.D.
Paris
1895-1961

John Calvin Hart, M.D., who retired from his practice in Paris and Bourbon County in April, 1960, died at Silver Springs, Florida, on June 16.

A native of Illinois, Doctor Hart graduated from the University of Louisville School of Medicine in 1920 and began practice in Clintonville before moving to Paris where he practiced for 40 years. A member of the KSMA and the Bourbon County Medical Society, he was 66.

R. W. KITTINGER, M.D.
Cromwell
1894-1961

A practicing physician in Ohio and Butler counties for many years, R. W. Kittinger, M.D., Cromwell, died in Owensboro-Daviess County Hospital on June 11. He had practiced medicine in Sutherland, Logansport, Cromwell and Morgantown. A native of McLean County, Doctor Cromwell was 77.

WILLIAM CLARENCE McCAULEY, M.D.
Versailles
1868-1961

William Clarence McCauley, M.D., Versailles, who had served that city as a physician and long-time Mayor, died June 3 at Woodford Memorial Hospital after a long illness. He was 92.

Doctor McCauley, a graduate of Bellevue Medical College, New York City, practiced medicine in Versailles from 1894 until his retirement in 1954. He figured prominently in the civic life of Versailles for 34 years and was its only seven-term Mayor, from 1923-1949.

E. W. MONTGOMERY, M.D.
Vine Grove
1876-1961

A general practitioner for over 60 years, E. W. Montgomery, M.D., died of a heart attack at his home in Vine Grove on June 30. Doctor Montgomery graduated from the University of Louisville School of Medicine in 1900, after which he began practice in Hardin County, first in Solway and Vertrees before moving to Vine Grove in 1909.

Doctor Montgomery was 85. He was honored in 1950 by friends and colleagues in the medical profession for his half century of practice.

HORACE MORRIS, M.D.
Louisville
1883-1961

Horace Morris, M.D., a Louisville physician for 48 years and City school physician for over 30 years, died at his home on June 25. Doctor Morris received his medical degree from Howard University School of Medicine, Washington, D. C., in 1913. He was 78.

HOY NEWMAN, M.D.
Bowling Green
1898-1961

Hoy Newman, M.D., a Bowling Green physician and surgeon for many years prior to his retirement about five years ago, died at his home July 6. Doctor Newman received his medical degree from Vanderbilt University Medical School in 1924.

FRED P. STROTHER, M.D.
Madisonville
1875-1961

A physician and businessman in Madisonville for 50 years, Fred P. Strother, M.D., died June 18 at Vanderbilt Hospital, Nashville, at the age of 86.

Doctor Strother, a native of Rochester, began practice in Madisonville after graduation from the University of Louisville Medical Department in 1903. He was a director of Kentucky Bank and Trust Company, Madisonville, for over 25 years and had been a vice-president of Madisonville Building and Loan Association from its organization until resigning recently. He had also taught school at Rochester and had once owned a drugstore there.

JOHN GARLAND CARTER, M.D.
Augusta
1905-1961

John Garland Carter, M.D., died of a heart attack July 5 at his home in Augusta. The 55-year-old physician and surgeon was one of only two in Augusta. A native of Louisa, he studied at the Universities of Louisville and Tennessee, receiving his medical degree from the U. of Tennessee in 1931. He interned at the Memphis Receiving Hospital.

Doctor Carter practiced in Louisa before going to Augusta in 1939. He was a member of the KSMA and the AMA.

Ohio Surgeons To Meet

The Ohio Chapter of the American College of Surgeons invites Kentucky physicians, associates and residents to attend its Sixth Annual Meeting at the Netherland Hilton Hotel, Cincinnati, Ohio, September 22 and 23. A number of panel discussions will highlight the two-day meeting at which a Louisville physician, Arnold R. Griswold, M.D., will moderate a panel on "Management of Non-Penetrating Abdominal Trauma."

Joseph D. Stokes, M.D., a native of Earlington, has joined the Muhlenberg Community Hospital and Logan County Hospital as radiologist. Doctor Stokes graduated from the University of Louisville School of Medicine in 1957 and interned at St. Joseph Infirmary in Louisville. He took his residency training at two Nashville, Tenn., hospitals: Thayer V. A. Hospital and Vanderbilt Hospital.

Carlisle Morse, M.D., Louisville, was re-elected Kentucky Councilor to the American Diabetes Association at its meeting held in New York in conjunction with the AMA meeting in June.

James Turner, M.D., who has been with the Lynch Medical Services since March, 1959, has been named head of the Cumberland Valley Medical Group and will be director of the Lynch Medical Services and the Cumberland Clinic. He replaces Louis Hamman, M.D., who resigned July 1 to accept a post at Hickory, N. C.

Edmund D. Pellegrino, M.D., Lexington, played the part of a consulting internist in several scenes of "Dr. B.", the hour-long TV program in tribute to the family doctor aired by NBC during the AMA meeting in June. The show was filmed at the Hunterdon Medical Center, Flemington, N. J., before Doctor Pellegrino came to Kentucky as chairman of the department of medicine at the University of Kentucky College of Medicine.

Roy J. Moser, M.D., a 1954 graduate of the Loyola Medical School in Chicago, has begun practice in internal medicine in association with **C. C. Hugan, M.D.,** Covington. Doctor Moser interned at Good Samaritan Hospital, Cincinnati, and took his residency training at Veterans Administration Hospital, Louisville, and Henry Ford Hospital, Detroit. He served in the Army for two years at Army Hospital, Fort Benning, Ga., with the rank of captain.

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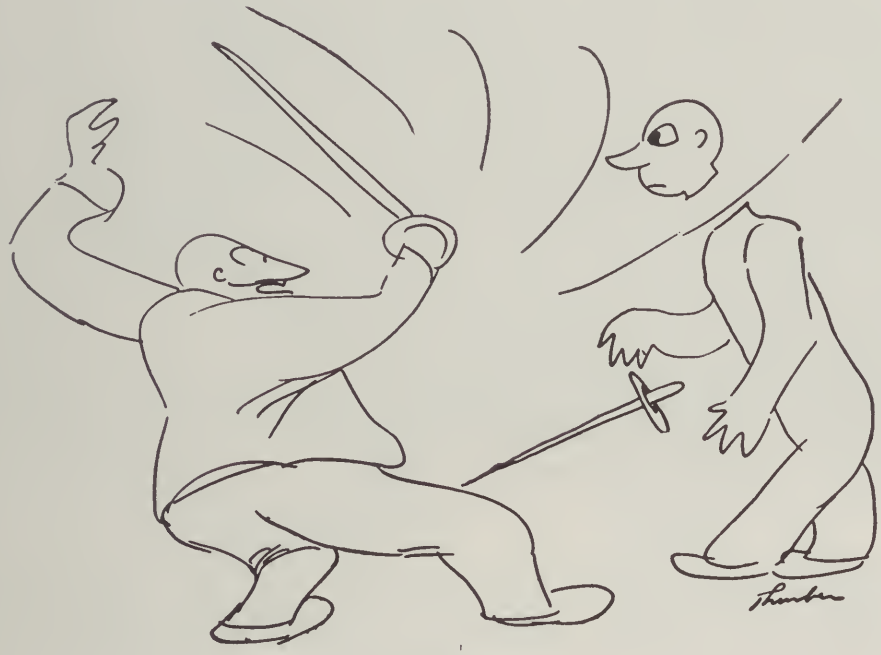
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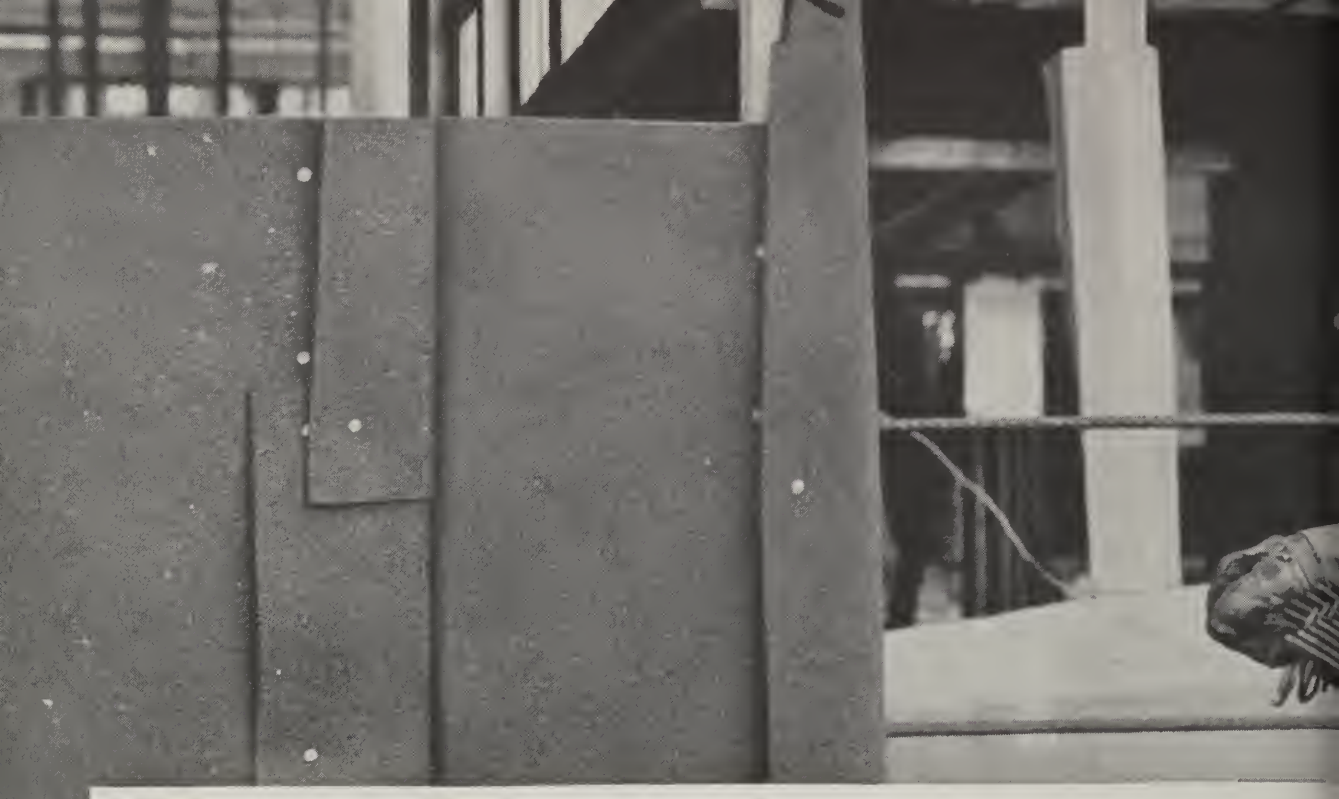
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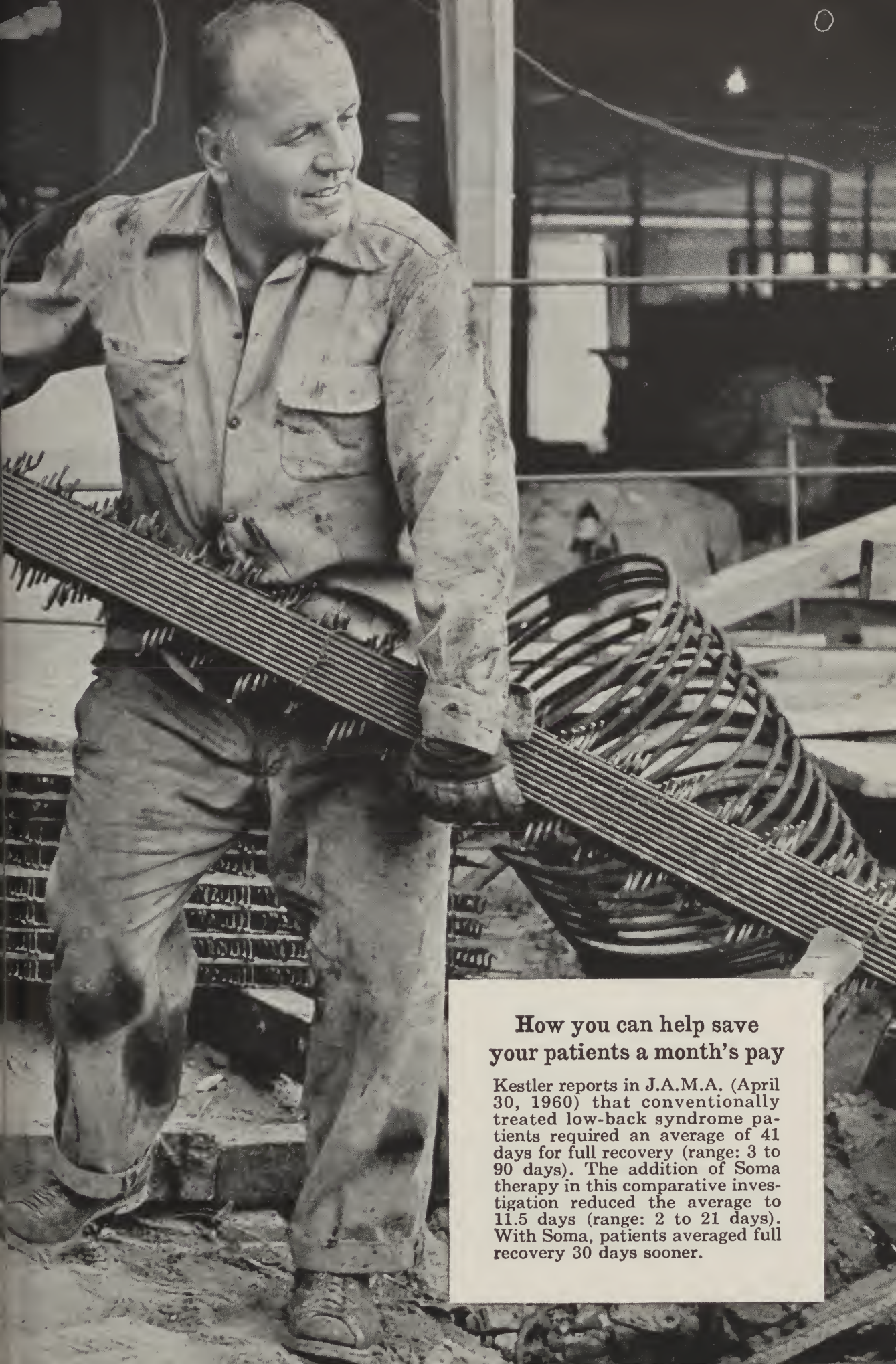
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IN THE BOOKS



SIGHT, A HANDBOOK FOR LAYMEN: by Roy O. Scholz, M.D.; published by Doubleday & Company, Inc., Garden City, New York, N. Y.; 1960, 166 pages; price, $3.50.

The author of this book is an eminent ophthalmologist from Baltimore, Maryland, who, as well as being Chief of Service of the Department of Ophthalmology in several hospitals around Baltimore, is currently Ophthalmologist-in-charge at the Johns Hopkins Dispensary. In his own words, the book's purpose is to "answer the many intelligent questions patients ask their eye doctors. As the answers are frequently complex, it was designed to enable the patient, at his leisure, to gain a broad, non-technical view of the functioning of the eye in health and disease. It is not intended as an aid to diagnosis, but to give the layman a better understanding of the problems of vision."

The book is well arranged and written in a language that can be understood readily by most everyone, even though the reader has had no medical training or experience.

There are thirteen illustrations of general eye structure and refractive and optical principles, involving the normal and problematical states of the eye. There are also lucid discussions of the physiological factors of partial blindness, the advantages of early diagnosis and treatment of eye troubles in children, advances in treating injuries, optical aids, and contact lenses. In the last four pages of the book, there is a glossary of terms which gives clear and concise definitions of the most commonly used terms in eye disease.

I feel that this is a useful book and am sure that it will be of distinct value to nurses, public health workers, and teachers. I feel, too, that it would be a worthwhile addition to the office library of ophthalmologists, pediatricians, and general practitioners, for the purpose of reference by their patients or patients' families. Also, I feel that this book should be included in every public school library for student and teacher reference.

Charles O. Bruce, M.D.

PHARMACOLOGY: THE NATURE, ACTION AND USE OF DRUGS: by Harry Beckman, M.D.; published by W. B. Saunders Company, Philadelphia and London; Second edition, 1961; 805 pages plus xvii; price, $16.50.

This work, intended for the use of medical undergraduates, first appeared in 1958 under the title "DRUGS," and its success has warranted expansion by five chapters and by 77 pages to the present size; unfortunately the price has also expanded by a dollar and a half. The organization of the first edition has again been used, but there is evidence throughout of complete and critical revision, with some references as recent as Spring 1960. The omission of two valuable and interesting chapters in the first edition from the contents of the second is nowhere explained; these were Chapter 75 on radioisotopes and Chapter 76 on drugs used in special diagnostic procedures.

This work deals with medical practice rather than with laboratory pharmacology. It is written in an enthusiastic style that makes it pleasant to read. Its organization makes it an easy reference. The inclusion of innumerable structural formulas and much consideration of structure-action correlations, makes it lucid and memorable.

The University of Louisville Medical School can again be proud of the service rendered by this scholarly alumnus.

Austin Bloch, M.D.

A MANUAL OF CUTANEOUS MEDICINE: by Donald M. Pillsbury, M.D., D. Sc., M.D., F. A. C. P., Walter B. Shelley, M.D., Ph.D., F. A. C. P., and Albert M. Kligman, M.D., Ph.D.; published by W. B. Saunders Company, Philadelphia and London; 430 pages; price $9.50.

One of the goals set forth by this top echelon trio of dermatologists in the preface of "A Manual of Cutaneous Medicine" is:

"To summarize, with as much completeness as possible within a manageable number of pages, the chief useful facts regarding the diagnosis, prevention and cure of the diseases affecting the skin which are encountered in daily practice." This they have accomplished in a gratifyingly satisfactory fashion.

After an adequate discussion of the basic principles of the physiology, chemistry and pathology of the skin, there follows a practical discussion of the diagnosis and treatment of most skin disorders of interest to the generalist, medical student or specialist other than the dermatologist.

Besides covering the usual classification and range of skin diseases, it includes valuable sections on the use of griseofulvin; a critical evaluation of steroid therapy; and management of cellular nevi and hemangiomas. Photographs and illustrations throughout the book are excellent.

The entire manual is concise and practical in its tone. Consequently, details and discussions of complications are virtually eliminated. Tangentially, as an "offspring" of this, the authors try to differentiate between those conditions that can be managed in general practice and those which should be referred to the dermatologist.

At times, their brevity makes certain statements

(Continued on Page 813)

In The Books

(Continued from Page 812)

appear quite dogmatic, although this is no doubt done for the sake of clarity. This feeling was strongest in their six and a half page discussion of as broad a subject as syphilis. This does not, however, detract from the general utility of the book.

In brief, this manual is well written, its style is clear, its suggestions are useful and realistic, and it has an excellent appended formulary. It can be highly recommended as an extremely worthwhile addition to the library of the practicing physician.

Maurice T. Fliegelman, M.D.

Case Discussion

(Continued from Page 756)

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Frederick Edward Kratter, M.D., a native of England and formerly staff psychiatrist at Pineland Hospital, Pownal, Maine, has been named clinical director of Western State Hospital Hopkinsville. **H. W. Conran, M.D.**, superintendent of the hospital, announces that Doctor Kratter will fill the vacancy left by **Mehmet S. Akaydin, M.D.**, who resigned last November.

Robert C. Pronko, M.D., Pineville, has left his practice to become one of three doctors at a mission hospital run by the Home Mission Board of the Congregational Christian Church in the village of Humacao, Puerto Rico. Doctor Pronko, a 1952 graduate of Washington University School of Medicine, St. Louis, spent two years in Humacao before coming to Bell County.

AHA Meets Sept. 25-28

Theme for the 63rd annual meeting of the American Hospital Association is "Hospitals in a Changing America." Twelve thousand people are expected to attend the September 25-28 meeting in Atlantic City. The 127-member House of Delegates, the Association's policy-making body, will meet on the mornings of September 26-28 at the Traymore Hotel, and there will be more than 40 program sessions and nearly 500 exhibits at the Atlantic City Convention Hall.

Dr. Leavell Honored

Hugh R. Leavell, M.D., Professor and Head of the Department of Public Health Practice and Assistant Dean, Harvard School of Public Health, was twice honored during April by colleagues in the public health profession. On April 10 he was elected President of the Association of Schools of Public Health, Inc., and on April 20, he received the Lemuel Shattuck Award from the Massachusetts Public Health Association. Doctor Leavell, who ran the old Louisville Health Department from 1934 to 1942, then directed the newly merged City-County Health Department for two years, recently visited Louisville to observe public health administration. He will present his information in the form of a case study to his Harvard students.

Zygmet S. Gierlach, M.D., Lexington, who has been chief radiologist with Central Baptist Hospital since it opened, will succeed **Jesse Smith, M.D.**, as radiologist at the Bourbon County Hospital.

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From the files of the COMMITTEE FOR THE STUDY OF MATERNAL MORTALITY



CASE #73—A forty year old white gravida 8 para 7 was seen by her physician initially in the fifth month of pregnancy. She made four prenatal visits. She was Rh positive. Serologic tests were negative for syphilis.

	Month Of Pregnancy								
	1	2	3	4	5	6	7	8	9
Blood Pressure					102/60	110/65	120/70	110/64	
Weight					113	116½	120	122	
Urine					Neg	Neg	Neg	Neg	
Hb					70%		80%		

Four weeks before the patient was hospitalized, she experienced slight vaginal bleeding. She entered labor spontaneously on August 22 after spontaneous rupture of membranes. The first stage of labor lasted three hours. She had bled moderately for approximately one-half hour before she was examined, but neither the dilatation of the cervix nor the amount of bleeding were recorded. The information supplied stated only that she was given nitrous oxide, examined, and then began to bleed profusely. The placenta was pushed aside and a living three pound female infant was delivered by breech extraction. As the hemorrhage continued, IV fluids and a blood transfusion were started. It became apparent that this was a multiple pregnancy and a second three pound female infant, this one macerated, was delivered by version and extraction. The placenta was expressed while the patient was in moderate shock, and it was thought that after the uterus was emptied the bleeding might be controlled. Ergotrate and packing were used, but the bleeding persisted. The cervix was examined and found to be intact. A consultant was summoned but the patient died as he arrived, about forty-five minutes following delivery. There was no autopsy.

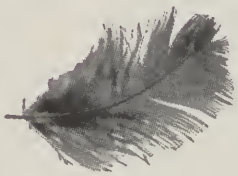
The cause of death as stated on the certificate was postpartum hemorrhage due to placenta praevia centralis associated with multiple pregnancy.

Comments

The committee classified this case as a direct obstetrical death with preventable factors. Since the membranes were stated to have ruptured, the diagnosis of placenta praevia centralis was untenable. Plunging the hand through the placenta to deliver the baby is certainly not an accepted obstetrical procedure. This case unfortunately demonstrates two of the hazards encountered in the "grand multipara": placenta praevia and uterine atony. As antepartum bleeding is often a warning sign of subsequent serious bleeding, blood should be available for transfusion before examining any bleeding patient. Regardless of the amount of cervical dilatation, cesarean section should be performed in every case of central placenta praevia and in most instances of malpresentation.

From the meager information supplied and without the benefit of an autopsy one cannot rule out the possibility of a traumatic rupture during the breech extraction of the first infant or the version and extraction of the second. The fact that bleeding continued after the placenta had been delivered strongly suggests such a possibility.

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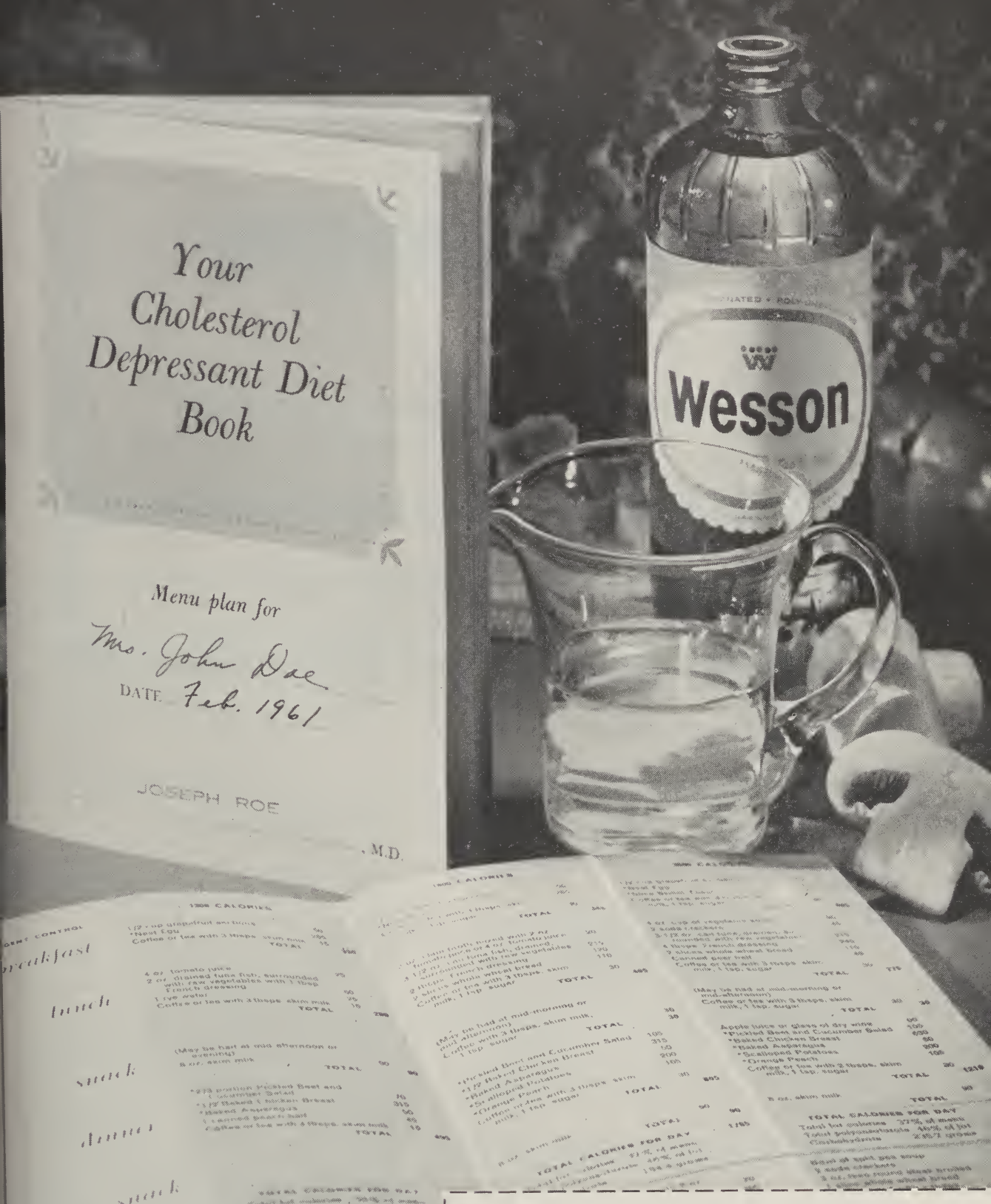
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Q.—How much more per month does Blue Shield cost on a direct basis than through a group?

A.—$.25 more for single members; $.50 more per family.

Q.—How many people in Kentucky who are over 65 years of age are Blue Shield members?

A.—Over 70,000.

Q.—How soon are claims paid after they are received by Blue Shield?

A.—Routine claims, with the form properly filled out, are paid within two weeks, depending on time of week the claim is received in the Blue Shield office. In cases where additional information or medical advice may be necessary, payment is delayed.

Q.—Does Blue Shield pay Workmen's Compensation cases?

A.—No. Services for industrial injuries or diseases for which the member is entitled to any benefit under Workmen's Compensation Laws are not paid for by Blue Shield. The employer is paying for Workmen's Compensation for such cases, and duplication of payment is unnecessary and increases the cost of protection and care. Members are not paying for such protection in their dues.

Q.—What are professional services as defined by Blue Shield?

A.—The term 'lprofessional services" means services rendered by Doctors of Medicine licensed under Chapter 311 Kentucky Revised Statutes, 1946, or similar chapters in codes of other states.

Q.—What is a "1" individual contract with Blue Shield?

A.—Type Contract "1" means the contract where member has applied for self only and is paying "single membership" fees. Type Contract "1" provides NO OBSTETRICAL BENEFITS.

Q.—What is a "2" family contract with Blue Shield?

A.—Type Contract "2" means the contract where member has applied for self and family and is paying "family membership" fees. Family includes the member, spouse, and unmarried children 30 days to 19 years of age. Each eligible person in the family is a "Beneficiary" and each is entitled to full benefits of the membership.

Q.—Is there an allowance to the doctor in maternity cases for home and office calls?

A.—No, there is only one allowance toward delivery including postnatal and prenatal care.

Q.—What action is planned to improve communications between the doctors and Blue Shield?

A.—The Physicians Service Department has increased its staff to five Special Representatives. This will enable a personal visit to a physician's office quicker and more often to discuss matters of mutual concern. The Blue Shield Staff is also preparing a quarterly Newsletter to all Kentucky physicians which will contain articles that will help eliminate this communications barrier. Close liaison will be maintained between the staff and committees of the KSMA and county medical societies. Members of the Blue Shield Staff are available at any time to meet with doctors, committees of doctors or county medical societies. Requests should be made to the Physicians Service Department, 3101 Bardstown Road, Louisville 5, Kentucky, or Branch Offices.

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PUBLIC HEALTH PAGE

Phenylketonuria†

RUSSELL E. TEAGUE, M.D. *Commissioner of Health, Commonwealth of Kentucky*

PHENYLKETONURIA or phenylpyruvic oligophrenia is a congenital metabolic disease which is associated with mental deficiency. It is important as a public health problem because, as a rule, (90% of cases) the resulting mental deficiency is so severe as to require institutional or custodial care of the victim. Since retardation can be prevented if the condition is diagnosed and treated early in life, considerable expense as well as individual suffering can be prevented if these cases can be identified in infancy. For this reason health departments throughout the country have become interested in testing programs designed to bring these patients to light despite the estimated low incidence (1/20,000 births),

Screening procedures are based on the detection of phenylpyruvic acid in the urine. This is accomplished by the addition of a drop of 10% ferric chloride to the urine or to a wet diaper. A positive test is indicated by the fleeting appearance of a blue-green or grey-green color. Another method of testing is by use of "Phenistix" developed by Ames Laboratories. A paper strip impregnated with a buffered ferric salt is dipped into the urine or pressed against a wet diaper. The presence of phenylpyruvic acid is indicated by the appearance of green color in the strip. Positive urine tests must be confirmed by phenylalanine determinations on the patient's serum. It is important to note that while urine tests may not be positive before the infant is 2 or 3 months old, the blood phenylalanine levels will be abnormally high within two to three days after birth. Thus in suspected cases, for example, where an older sibling has been diagnosed as having the disease, blood tests should be done in the postnatal period.

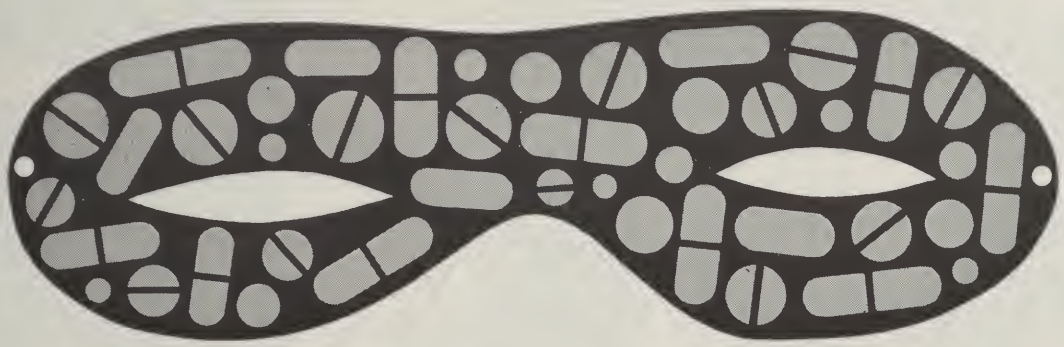
A testing program has been initiated in Kentucky during the past year, using Phenistix which were supplied by Ames Laboratories. Local health department personnel have been instructed to test all preschool age children which come under their supervision and to report any positive cases to the Bureau of Maternal and Child Health. In addition, a testing program has been initiated among "high-risk" populations, i.e.—known mentally retarded children and their siblings. Follow-ups are being done on the families of the twelve known cases at the Kentucky Training Home, and all of the children in the Stevens School in Louisville have been tested. Similarly, chidren who are on the waiting list for admission to the Kentucky Training Home are being contacted and tested. To date approximately twenty previously unknown cases have been found. Not all of these have been confirmed by blood studies owing to the fact that blood samples must be sent out of the state for testing.

When cases are confirmed by blood sudies the Bureau of Maternal and Child Health can assist families by providing a special diet which consists of a synthetic "milk" preparation* which is low in phenylalanine. Our nutritionists are also available to help the mother or doctor plan a diet which will keep the phenylalanine intake at an acceptable level.

In recent years there has been an increasing interest in the congenital metabolic diseases, with their possible concomitant defects. Phenylketonuria has come in for a large share of this attention owing to the discovery that it can be prevented by early dietary management. (Galactosemia is of course a similar but more deadly metabolic abnormality.) There is considerable surmise on the part of researchers that other metabolic errors may be related to mental deficiency and that further research may render these treatable. There is a great need for continued research in this area and also for a method of identifying the "carrier" state of phenylketonuria. It is encouraging to note that both of our medical centers in Kentucky plan research projects in this important field.

†*This article was prepared by Helen B. Fraser, M.D., M.P.H., Director, Bureau of Maternal & Child Health, Kentucky State Department of Health, Frankfort, Kentucky.*

**Lofenalac, made by Mead, Johnson & Co., Evansville, Indiana.*



drugs anonymous

One of the several hastily conceived and potentially dangerous suggestions for reducing drug costs is generic-name prescribing. The proponents of generic-name prescribing claim that it will lower drug costs significantly and—through supervision by the Federal Government—provide quality equivalent to that of trademarked drugs. We maintain that these claims are false. Here are some authoritative answers to the principal questions posed by generic-name prescribing.

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"The [Rhode Island] Division of Public Assistance examined 10,000 drug prescriptions for welfare recipients for the purpose of determining the actual savings . . . of generic versus trade-name drugs. The drugs had cost $28,000. Substituting generic drugs whenever possible would have provided a saving of less than 5 per cent. Syracuse has made a similar study of drug costs with comparable results."

Rhode Island Medical Journal,
January, 1961

Are the savings worth the risk of sacrificing quality?

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SPECIAL PROBLEM: EDEMA

Since it does not produce edema, triamcinolone is useful in rheumatoid arthritis patients with cardiac decompensation who need steroid therapy. (Hollander, J. L.: *J.A.M.A.* 172:306 [Jan. 23] 1960.)

SPECIAL PROBLEM: HYPERTENSION

Triamcinolone may be included among the currently available antirheumatic steroids having the least tendency to cause sodium retention. (Ward, L. E.: *J.A.M.A.* 170:1318 [July 11] 1959.)

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Precautions: Collateral hormonal effects generally associated with corticosteroids may be induced. These include Cushingoid manifestations and muscle weakness. However, sodium and potassium retention, edema, weight gain, psychic aberration and hypertension are exceedingly rare. In the treatment of rheumatoid arthritis, dosage should be individualized and kept at the lowest level needed to control symptoms. Dosage should not exceed 36 mg. daily without potassium supplementation. Drug should not be withdrawn abruptly. Contraindicated in herpes simplex and chicken pox.

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references: (1) Lish, P. M.; Albert, J. R.; Peters, E. L., and Allen, L. E.: Arch. internat. pharmacodyn. *129*:77-107 (Dec.) 1960. (2)Howell, C. M., Jr.: North Carolina M. J. *21*:194-195 (May) 1960. (3) Clinical Research Division, Mead Johnson & Company. (4) Wahner, H. W., and Peters, G. A.: Proc. Staff Meet. Mayo Clin. *35*:161-169 (March 30) 1960. (5) Crepea, S. B.: J. Allergy *31*:283-285 (May-June) 1960. (6) Crawford, L. V., and Grogan, F. T.: J. Tennessee M. A. *53*:307-310 (July) 1960. (7) Spoto, A. P., Jr., and Sieker, H. O.: Ann. Allergy *18*:761-764 (July) 1960. (8) Arbesman, C. E., and Ehrenreich, R.: New York J. Med. *61*:219-229 (Jan. 15) 1961.

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(1) Carter, S.: *M. Clin. North America* 37:315, 1953.
(2) Maltby, G. L.: *J. Maine M. A.* 48:257, 1957.
(3) Buchthal, F.; Svensmark, O., & Schiller, P. J.: *Arch. Neurol.* 2:624, 1960.

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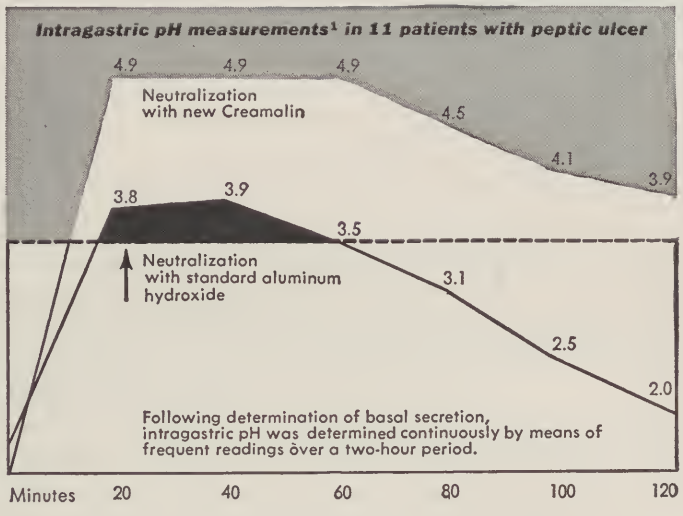
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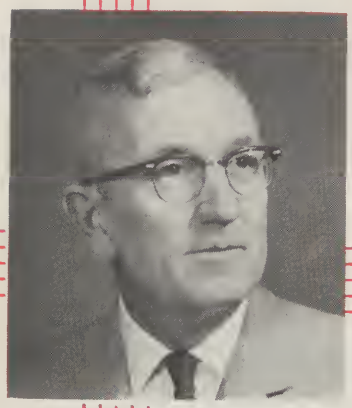
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MESSAGE FROM THE PRESIDENT

THIS is my last President's Page and before I give up this opportunity of self expression which I have enjoyed for the past twelve months I would like to recognize two groups of our membership whose work too often goes unnoticed. I refer to the members of the many committees of KSMA and the secretaries of the county medical societies. Without their devotion and work organized medicine in Kentucky would not be the force that it is.

The greater part of the planning of the affairs of KSMA are carried on by these committeemen. They travel to Louisville at their own expense from all parts of the state for committee meetings where they spend hours working on the problems of the Association. Many give added time and effort to matters of special importance to their committees so that the reports will be of increased value to the House of Delegates.

The secretary is the key man in each county society through whom cooperation and liaison with the State Association is maintained. This position is the most demanding in the society and if it is not competently filled the work of the society is not effective. We are blessed in Kentucky with many fine and able men in this duty and KSMA has benefitted a great deal from their help and suggestions.

I have had an opportunity during the past year to see both groups at work and I want to thank each of you for what you have done. Without your efforts the job could not be completed.

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"nutrition...present as a modifying or complicating factor in nearly every illness or disease state"[1]

1. Youmans, J. B.: Am. J. Med. 25:659 (Nov.) 1958

cardiac diseases "Who can say, for example, whether the patient chronically ill with myocardial failure may not have a poorer myocardium because of a moderate deficiency in the vitamin B-complex? Something is known of the relationship of vitamin C to the intercellular ground substance and repair of tissues. One may speculate upon the effects of a deficiency of this vitamin, short of scurvy, upon the tissues in chronic disease."[2] 2. Kampmeier, R. H.: Am. J. Med. 25:662 (Nov.) 1958.

arthritis "It is our practice to prescribe a multiple vitamin preparation to patients with rheumatoid arthritis simply to insure nutritional adequacy . . ."[3]
3. Fernandez-Herlihy, L: Lahey Clinic Bull. 11:12 (July-Sept.) 1958.

digestive diseases Symptoms attributable to B-vitamin deficiency are commonly observed in patients on peptic ulcer diets.[4] Daily administration of therapeutic vitamins to patients with hepatitis and cirrhosis is recommended by the National Research Council.[5] 4. Sebrell, W. H.: Am. J. Med. 25:673 (Nov.) 1958. 5. Pollack, H., and Halpern, S. L.: Therapeutic Nutrition, National Academy of Sciences and National Research Council, Washington, D. C., 1952, p. 57.

degenerative diseases "Studies by Wexberg, Jolliffe and others have indicated that many of the symptoms attributed in the past to senility or to cerebral arteriosclerosis seem to respond with remarkable speed to the administration of vitamins, particularly niacin and ascorbic acid. These facts indicate that the vitamin reserve of aging persons is lowered, even to the danger point, more than is the case in the average American adult."[6] 6. Overholser, W., and Fong, T.C.C. In Stieglitz, E. J.: Geriatric Medicine, 3rd edition, J. B. Lippincott, Philadelphia, 1954, p. 264.

infectious diseases Infections cause a lowering of ascorbic acid levels in the plasma; and the absorption of this vitamin is reduced in diarrheal states.[7] 7. Goldsmith, G A.: Conference on Vitamin C. The New York Academy of Sciences, New York City, Oct. 7 and 8, 1960. Reported In: Medical Science 8:772 (Dec.10) 1960.

diabetes Diabetics, like all patients on restricted diets, require an extra source of vitamins.[8] "Rigidly limiting the bread intake of the diabetic patient automatically eliminates a large amount of thiamin from the diet. . . . There is some evidence of interference with normal riboflavin utilization during catabolic episodes."[9]
8. Duncan G. G.: Diseases of Metabolism 4th edition W. B. Saunders, Philadelphia, 1959, p. 812. 9. Pollack, H.: Am. J. Med. 25:708 (Nov.) 1958.

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THE INSURANCE PAGE



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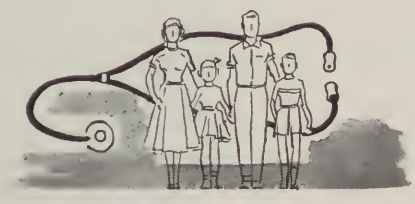
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**This is an adaptation of an article by Richard J. Ackart, M.D., Richmond, Va., published recently in another journal and is being presented by permission of the author.*



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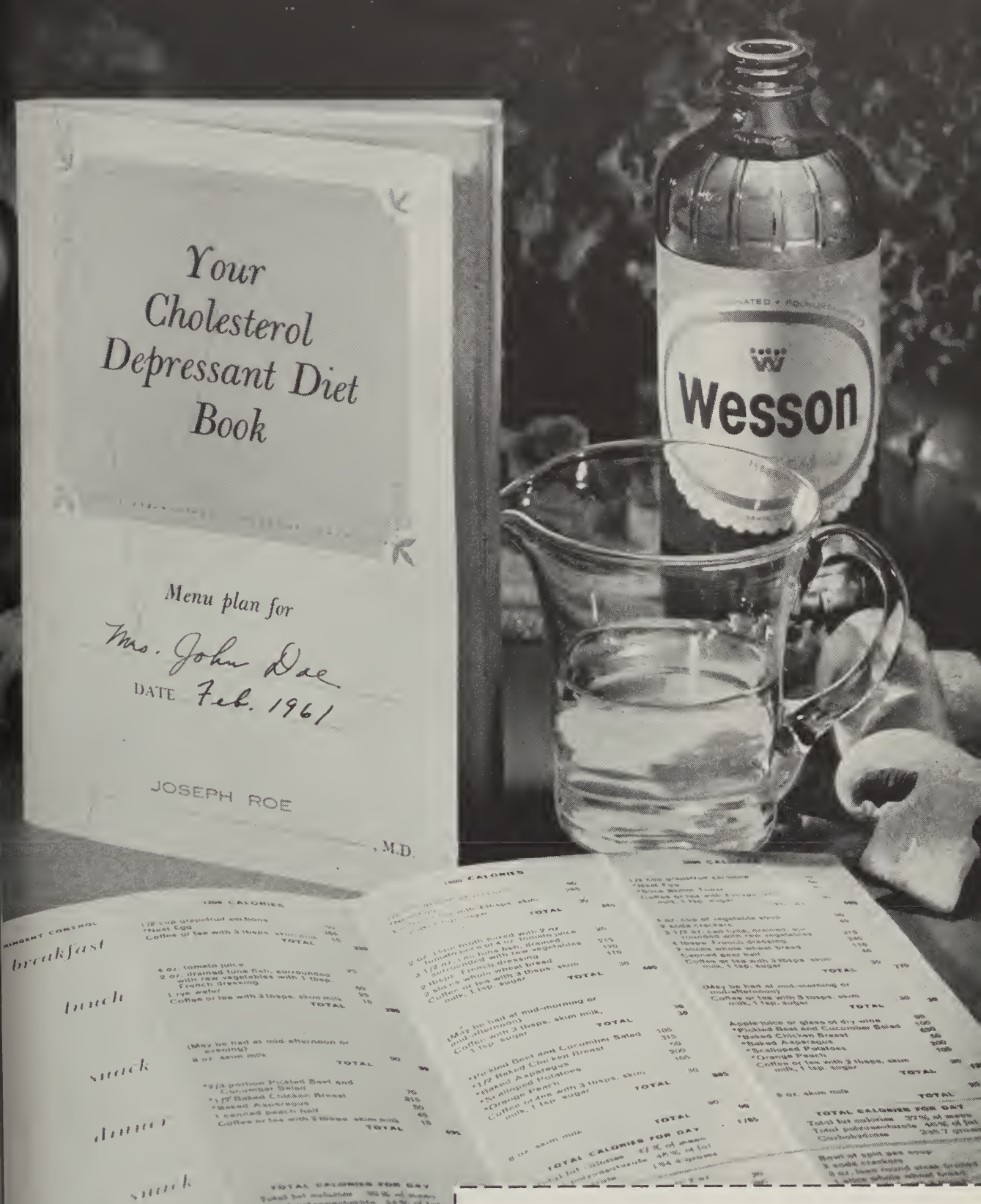
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WASHINGTON NEWS DIGEST

The American Medical Association cited more than 50 reasons why the vast majority of the nation's physicians believe the Administration's medical care program would be "bad medicine for the people of this country."

The AMA's objections to the proposal were spelled out in a detailed, 91-page printed statement presented to the House Ways and Means Committee by Leonard W. Larson, M.D., Bismarck, N.D., president of the A.M.A.

The committee held two weeks of hearings (July 24-Aug. 5) on the Administration proposal (H.R. 4222) which would provide limited hospitalization, nursing home care and outpatient diagnostic services for social security recipients. The program would be financed by an increase in payroll taxes on workers, employers and the self-employed.

Doctor Larson declared that the Administration program would force upon Americans a system of health care in which the quality of medical care would deteriorate, in which quality would become secondary to cost.

He said American medicine is the best in the world, medical education unsurpassed and the qualifications of U.S. physicians unmatched.

"Ours is a dynamic system of health care—and it works," he said. "The very fact that we now have 16½ million Americans 65 years of age and older proves that it works.

"Yet, this same system of medical care is now under attack. At a moment when American medicine is pre-eminent throughout the world, it is proposed that we adopt the very systems under which one European nation after another has lost its former leadership in medical science.

"The staggering costs of such plans, the administrative problems they create—let these considerations be secondary," he said. "The important thing is to see, at close range, the disruption of the doctor-patient relationship; the delays in admission to hospitals; the time wasted in the over-crowded offices of doctors; the regimentation of medical practice; the effect of the program on medical research; the availability of medical facilities and personnel—in other words, medicine in action on a government-run, assembly-line basis."

Doctor Larson said also:

1. Congress is being asked to plunge into a compulsory government-operated program of health care for certain of the country's elderly without knowing what even the first-year cost will be—whether $1 billion or $4 billion— and without any clear idea of the extent of the problem it seeks to solve.

2. The bill under consideration would give a single government official the power to "become the nation's czar of hospital care."

3. Contrary to statements of supporters of the measure that physicians' services are not included in the program, more than 50,000 doctors would be directly affected by regulations and controls exercised by government over operations and administration of hospitals.

4. Enactment of the program would "lower the quality of medical care available to the older people of the United States" because "it would introduce into our system of freely practiced medicine elements of compulsion, regulation and control" by government.

5. The Administration proposal is unnecessary in light of the true economic status of the aged and because of the spectacular rise of voluntary, private health insurance coupled with passage by Congress of the Kerr-Mills Medical Aid for the Aged Law last year and the existence of other public and private programs of aid to the needy.

6. Health care at the expense of the working people would be provided for millions who are financially able to pay for their own care.

7. The legislation "proposes that we distrust the brains and capacities of today's Americans" because "it suggests that the aged—as an entire group—are not capable of looking after their own affairs and providing for their own needs."

8. Increasing costs of the program could impose such a financial strain on social security that the entire system could be jeopardized.

9. The administration's bill is just as objectionable as the five similar health care proposals rejected by Congress since 1942.

10. The bill would violate "American ideals of independence, self-sufficiency and personal responsibility" by establishing a system in which medical aid would be provided not on the basis of need but on the basis of age.

Doctor Larson described estimates of the cost of the Administration program as "confusing."

The AMA president reminded committee members that HEW Secretary Abraham Ribicoff had told them that "a closer study" had revealed it would be necessary to increase the taxable wage base from the present $4,800 to $5,200, rather than the $5,000 fixed in the bill when it was introduced.

He also pointed out that HEW originally had said nursing home services during the first year of opera-

(Continued on Page 899)



in bacterial otitis media Panalba* promptly to gain precious therapeutic hours

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Acts safely – no danger of liver damage. Deprol does not produce liver damage, hypotension, psychotic reactions or changes in sexual function—frequently reported with other antidepressant drugs.

Bibliography *(13 clinical studies, 858 patients)*: **1.** Alexander, L. (35 patients): Chemotherapy of depression – Use of meprobamate combined with benactyzine (2-diethylaminoethyl benzilate) hydrachloride. J.A.M.A. 166:1019, March 1, 1958. **2.** Bateman, J. C. and Carlton, H. N. (50 patients): Meprobamate and benactyzine hydrochloride (Deprol) as adjunctive therapy for patients with advanced cancer. Antibiotic Med. & Clin. Therapy 6:648, Nov. 1959. **3.** Beerman, H. M. (44 patients): The treatment of depression with meprobamate and benactyzine hydrachloride. Western Med. 1:10, March 1960. **4.** Bell, J. L., Tauber, H., Santy, A. and Pulito, F. (77 patients): Treatment af depressive states in affice practice. Dis. Nerv. System 20:263, June 1959. **5.** Breitner, C. (31 patients): On mental depressions. Dis. Nerv. System 20:142, (Section Twa), May 1959. **6.** Gordan, P. E. (50 patients): Deprol in the treatment of depression. Dis. Nerv. System 21:215, April 1960. **7.** Landman, M. E. (50 patients): Clinical trial of a new antidepressive agent. J. M. Soc. New Jersey. In press, 1960. **8.** McClure, C. W., Papas, P. N., Speare, G. S., Palmer, E., Slattery, J. J., Konefal, S. H., Henken, B. S., Waod, C. A. and Ceresia, G. B. (128 patients): Treatment of depression – New technics and therapy. Am. Pract. & Digest Treat. 10:1525, Sept. 1959. **9.** Pennington, V. M. (135 patients): Meprobamate-benactyzine (Deprol) in the treatment of chronic brain syndrome, schizophrenia and senility. J. Am. Geriatrics Soc. 7:656, Aug. 1959. **10.** Rickels, K. and Ewing, J. H. (35 patients): Deprol in depressive conditions. Dis. Nerv. System 20:364, (Section One), Aug. 1959. **11.** Ruchwarger, A. (87 patients): Use of Deprol (meprobamate combined with benactyzine hydrochloride) in the office treatment of depressian. M. Ann. District of Columbia 28:438, Aug. 1959. **12.** Settel, E. (52 patients): Treatment af depressian in the elderly with a meprobamate-benactyzine hydrochloride combinatian. Antibiotic Med. & Clin. Therapy 7:28, Jan. 1960. **13.** Splitter, S. R. (84 patients): Treatment of the anxious patient in general practice. J. Clin. & Exper. Psychopath. In press, April-June 1960.

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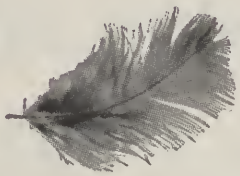
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References: 1. Santos, I. M. H., and Unger, L.: Ann. Allergy **18**:172 (Feb.) 1960. 2. Charlton, J. D.: Ann. Allergy, In press. 3. Shaftel, H. E.: Clin. Med. **7**:1841 (Sept.) 1960.

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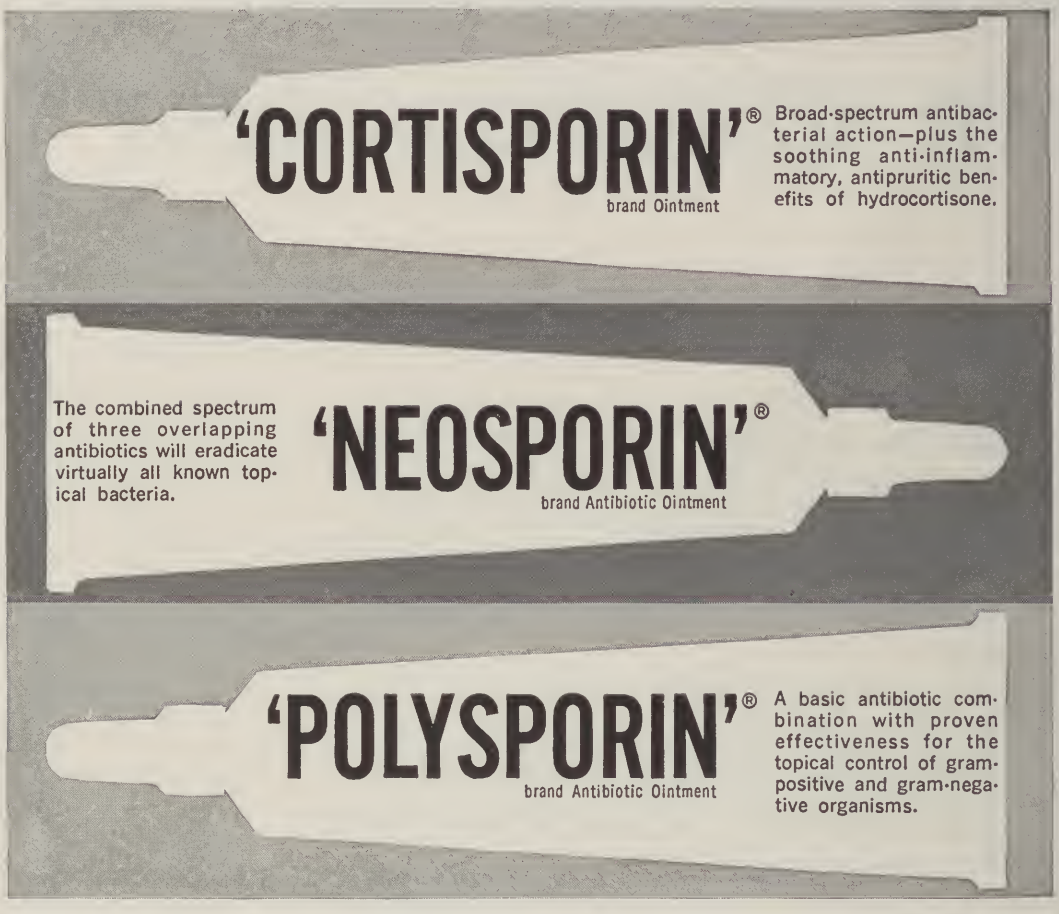
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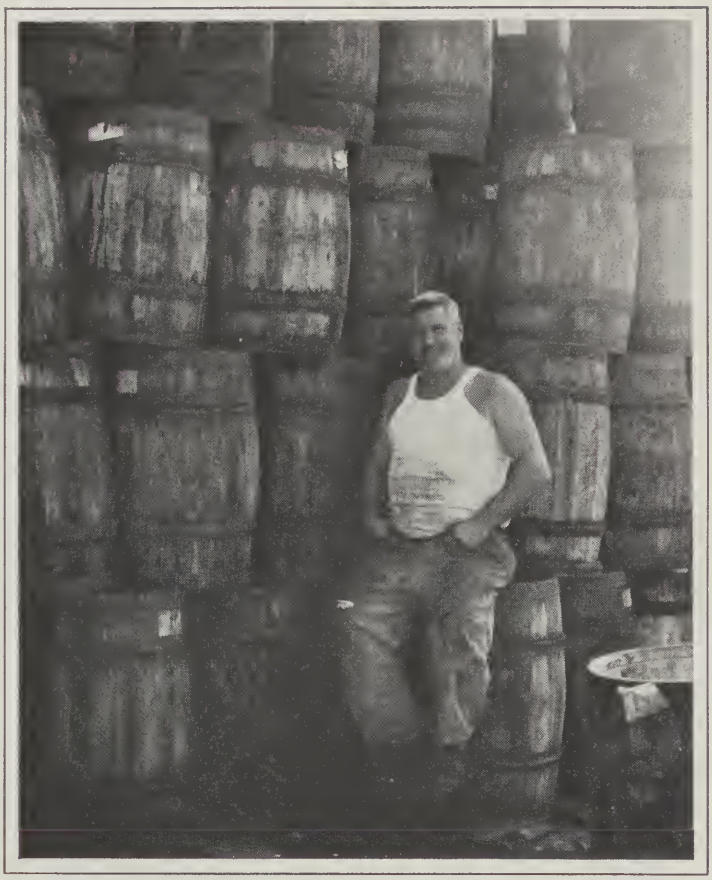
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*Gant, J. Q., Jr.: *M. Ann. District of Columbia 30*:267, 1961.

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A Study of Pulmonary Cavities

Oren A. Beatty, M.D.*

Louisville, Ky.

This study of pulmonary cavities demonstrates a difference in resistance of bronchi to a destructive tuberculous process which in turn determines the type of cavity and the structural changes in the bronchi and lungs.

THIS is a study of pulmonary cavities, employing the methods of intra-cavity pressure recording, auscultation and X-ray. Contrast material (Iodochloral®, Dionosil®, or Urokon®)was put into the cavities by the transthoracic method for x-ray investigation. The technique has previously been described.[1] Urokon was used in three cases and not used again because of febrile reactions. Most of the cavities were caused by tuberculosis. A few were post-resectional or from histoplasmosis or lung abscess.

Further knowledge of cavities and their bronchial communications, the reason for closure and non-closure and other useful information was gained. In some cases cavities were differentiated from blebs or bullae[2] and some cavities not previously shown by x-ray or other examinations were demonstrated. These studies have illustrated some of the mechanical problems and structural changes following the disease process. They also demonstrated that the resistance of bronchi to a destructive tuberculous process varies from patient to patient.

Theories and Findings

The findings in eighteen blocked tuberculous cavities were compared with eighteen open tuberculous cavities. Sinus tracts are seen more in the blocked cavities. Bronchiectasis and bronchial destruction are more common in the open cavities. The destruction of the bronchi in progressive cavitary disease is noted particularly in the open cases. Coryllos[3] described this and referred to the same observation by others. Neither Coryllos nor Eloesser described sinus tracts associated with blocked or open cavities. Auerbach and Green,[4] discussing the healing of tuberculous cavities, did describe an apical cavity with a caseous tract extending to the interlobar septum.

Coryllos[3] stated that tuberculous cavities would not close as long as they communicated with the outside world and that surgical collapse therapy acted by producing occlusion of the bronchus. He held that when this communication is occluded, the cavity collapses unless the walls present an insuperable resistance. Coryllos and Ornstein[5] stated that giant cavities are

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difficult to collapse because of the valve-like mechanism in the tension cavities and the wide open, draining bronchus in the open cavities.

Eloesser[6] rejected Coryllos' theory and looked upon cavities as being held open by direct attachments to the bony thoracic cage. In his view, when these attachments are severed by collapsing procedures, the cavity will shrink and close. He agreed with Coryllos and Ornstein[4] that tension cavities are difficult to close, but disagreed that blocked cavities close easily.

The studies presented herewith support the opinion of Eloesser[6] and demonstrate the framework which holds open a cavity. Completely occluded cavities do not close when they are held open by a supporting framework or superstructure.

Statistical Data

Seventy-seven cases are covered in this study, thirty-five of these having been reported previously.[1] These cavities have not closed with rest, drug and minor collapse therapy in some cases. Fifty-nine of these were open, nine partially blocked and nine were completely blocked cavities, as demonstrated by pressure and x-ray studies.

TABLE I—PULMONARY CAVITIES

	Number	Percent	Not prevously demonstrated
Open	59	78.0	6
Partially blocked	9	11.0	2
Blocked	9	11.0	4
TOTAL	77	100	12

In an open cavity the contrast medium is seen in both the cavity and bronchus on x-ray. In the partially blocked cavity it is seen in the cavity alone, but may be coughed out within 24 to 48 hours. When the contrast medium is not discharged from the cavity, it is completely blocked.

Pressures in cavities vary as to whether the cavity is open, partially blocked or completely blocked. Fifty-five open cavities had atmospheric pressures; five partially blocked cavities had positive pressures and six blocked cavities had negative pressures. In general, atmospheric pressures were found in open cavities, positive pressures in partially blocked cavities and negative pressures in completely blocked cavities. Pressures were not registered in two cavities because of purulent material present.

TABLE II—PRESSURES IN CAVITIES*

	ATMOSPHERIC	NEGATIVE	POSITIVE
Open	55	1	3
Partially blocked	2	?	5
Blocked	2	6	1
TOTAL	59	7	9

* Not found in two cases due to pus.

Tuberculous lesions more frequently occur posteriorly in the upper portion of the lung.[1] Cavities are more frequent in the same area. The disease which is posteriorly and superiorly located fixes the lung posteriorly by adhesions which become more extensive as the disease progresses. As the lobe or lung is destroyed, it contracts posteriorly toward the fixed point and the mediastinum and trachea move to this side with the opposite lung herniating across the anterior mediastinum. When the disease is anterior, the adhesions form and fix the lung anteriorly. This in turn tends to fix the mediastinum and prevents shift of the trachea. Shift of the trachea to the diseased side more frequently occurs in destructive cavitary disease when it is posteriorly located.

Structural Changes

Certain structural changes in the lungs or bronchi seemed to have a relation to whether a cavity was open or partially or completely blocked. The most frequent structural change was bronchiectasis, which occurred in 64.4% of the open cavities. No definite bronchiectasis was demonstrated in the blocked or partially blocked cavities. There were nine sinus tracts extending from the open cavities, three from the partially blocked and six from the blocked cavities. One-seventh of the open, one-third of

TABLE III—OTHER STRUCTURAL CHANGES

	TOTAL	BRONCHIECTASIS		SINUS TRACTS	
		Number	Percent	Number	Percent
Open	59	38	64.4	9	15.3
Partially blocked	9	0	0	3	33.3
Blocked	9	0	0	6	66.6
TOTAL	77	38		18	23.4

This table includes all the cavitary cases studied. Histoplasmosis and lung abscess and post resectional cavity spaces are included.

of the partially blocked and two-thirds of the blocked cavities had sinus tracts extending from them. Sinus tracts occurred almost four times more frequently in the blocked than in the open cavities. When the non-tuberculous and the post resectional cavities were eliminated, a comparison of sinus tracts showed they occur eight or nine times more frequently in the blocked cases.

A particular comparison is made of eighteen partially and completely blocked cavity cases with eighteen open cases. The non-tuberculous and post resectional cavity cases were eliminated from this group. TABLE IV gives the findings in these two groups. Significantly there appears to be more bronchial destruction in open cavitary cases and more sinus tracts in the partially and completely blocked cases. There were more bronchogenic spreads in the open and more diffuse infiltrative processes in the blocked cases. Surgical complications involving the bronchus occurred more frequently in the open cases.

TABLE IV

	OPEN CAVITIES		BLOCKED CAVITIES	
Number of cases	18		18	
Sputum positive	16		13	
Sputum negative	2		5	
Sputum conversion	12		6	
Bronchiectasis	14		0	
Sinus tracts	1		9	
Diffuse infiltrations	2		13	
Bronchogenic spreads	4		0	
Emphysema	6		7	
Number of resections	17		12	
Surgical bronchial Complications	6	35.3%	2	16.6%

This table compares the findings in eighteen blocked cavities with those of eighteen open cavities selected in alphabetical order.

Review of Findings

The following is a review of the findings which may show some reasons for the development of bronchiectasis and for the non-closure of cavities. Figure 1 shows large cyst-like cavities in a case of acute cavitary tuberculosis treated with combined drug therapy including isoniazid. Healing by resolution occurs in such cases before the development of bronchiectasis and before thick fibrous cavity walls develop. The cavity wall is only a thin membranous-like lining in these cases. Since it does not contain fibrous tissue, the elastic tissue of the surrounding lung expands it considerably.

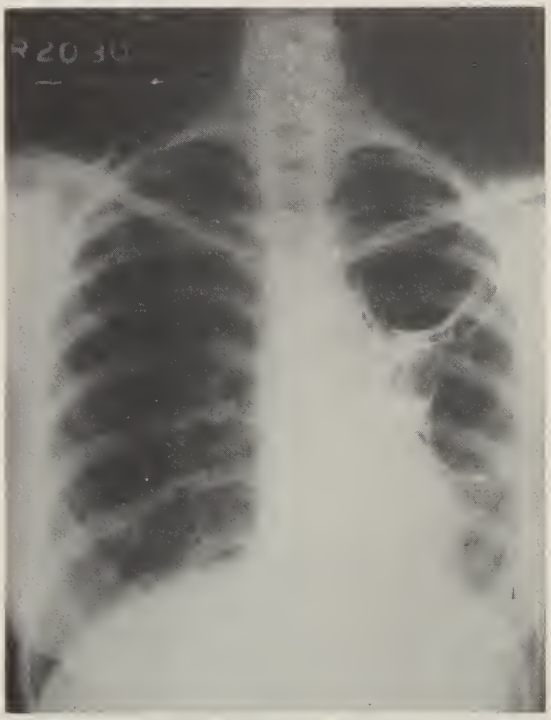


FIGURE 1—Large multilocular cystic cavity communicating with a bronchus.



FIGURE 2—Left infraclavicular cavity communicating through the bronchial tree with a smaller apical cavity. Bronchietasis is inferior and ventral to cavity. Superimposed drawing displaced to one side shows the single broncho-cavitary communication and the bronchiectasis.

What previously was a small cavity becomes a large air space or cyst in the lung.

Figure 2 shows a more chronic case which did not heal by resolution. Cavity study shows a moderate size infraclavicular cavity on the left which communicates with one bronchus. The iodized oil fills the bronchial tree and shows the bronchiectasis in the left upper lobe. The oil demonstrated a smaller apical cavity communicating with one bronchus. If untreated, these cavities increase in size and eventually coalesce. The first case healed by resolution and did not produce bronchiectasis. The second case did not heal by resolution and resulted in bronchiectasis as happens in unresolving pneumonia.

Figure 3 shows another case of tuberculosis in which cavity study reveals a moderately large cavity with multiple bronchial openings. There is more shrinkage and contraction of the lobe in this case in comparison with Figure 2.

Figure 4 shows still older disease. Cavity study shows the lobe practically destroyed and the bronchial openings reduced to one after the cavity enlarged and destroyed the lobe and its supplying bronchi. As this process continues, the mediastinum, trachea and mediastinal portion of the other lung are pulled toward the diseased side.

Figure 5 shows a completely blocked cavity with a sinus tract extending down toward the hilum. This has failed to close because of mechanical difficulties of blockage plus a surrounding superstructure of dense pleural adhesions. This type of cavity does not have proper drainage and a tuberculous sinus develops in 50% of the cases (Table III). The fact that the rate of incidence of sinus tracts increases with blockage suggests that the gravity of the prognosis of the cavity increases with blockage. This may not hold true for completely blocked cavities if ample drug therapy is used and if they are not suspended by a superstructure of dense pleural adhesions which prevents the relaxing collapse of the cavity.

Incorporated in Figures 2 through 4 are some drawings of cavities and their walls, scar tissue and overlying thickened pleura. These demonstrate that the predominant factor preventing closure in open cavities and completely blocked cavities is dense scar tissue with extensive adherent visceral and parietal pleura. In



FIGURE 3—Right apical cavity with multiple bronchial communications. The displaced superimposed drawing shows the superstructure of dense pleural adhesions which suspends the cavity and prevents closure.

the partially blocked cavity a ball valve mechanism plays the chief role in non-closure. Figure 6 represents this type of cavity.

These studies demonstrated cavities suspected but not previously shown by other types of x-ray examinations including stratigrams. Table I shows that there were twelve such cavities found. Figure 7 shows a cavity demonstrated by this method.

Discussion

Coryllos and Ornstein[5] believed that tension cavities and cavities with open draining bronchi are difficult to collapse. Eloesser[7] felt collapse procedures were more efficacious in the open communicating cavities. This study tends to corroborate the impression of Eloesser[7] and shows that open and completely blocked cavities do not close because of suspension to a dense surrounding superstructure. There is an elastic pull throughout the lungs. The diseased area is suspended within this. As a result of the inflammatory process there is fibrosis which contracts within the area to which it is limited and toward the fixed point where there are pleural adhesions. The cavity represents a



FIGURE 4—Right apical cavity with single bronchial connection. This cavity is held open by a superstructure of dense pleural adhesions as shown by the superimposed drawing displaced to the side.

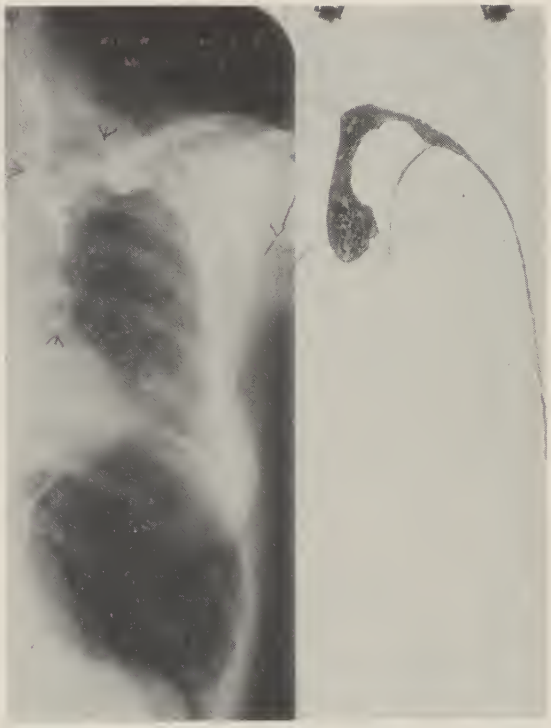


FIGURE 5—Left apical, completely blocked cavity. Note the sinus tract extending down behind the heart shadow and below the hilum. This was in the mediastinum. A high negative pressure was present in this cavity. The superimposed drawing which is displaced to one side, shows the super-structure of dense pleural adhesions which suspends the cavity and prevents closure.

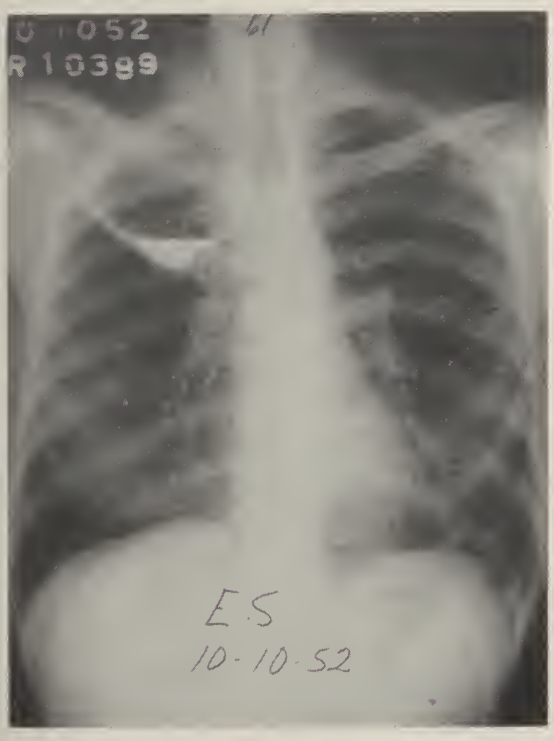


FIGURE 6—Right apical, partially blocked cavity. Note distention of cavity. Positive pressure was present. Cavity emptied in approximately 48 hours.



FIGURE 7—Left apical cavity not demonstrated by ordinary spot Bucky or stratigram x-rays was found and demonstrated by cavitary study. One or two bronchial communications demonstrated.

space where previously the central, denser area of tuberculous disease destroyed this portion of the lung. The progression of the disease may enlarge the cavity and contract the lobe. If there is freedom of contraction, the open cavity will close in retrogressing disease. Surrounding fibrosis attached to a superstructure of dense pleural adhesions will prevent freedom of contraction as seen in Figures 2 through 5. A partially blocked cavity traps air on inspiration and prevents closure. A completely blocked cavity may close if there is freedom of contraction around the cavity, and particularly in the presence of chemotherapy. Pottenger's[8] description of the mechanical factors interfering with the healing of tuberculosis was similar to the above.

Figure 1 compared to Figures 2 through 5 shows the effect of elastic tissue pull on cyst-like cavities in contrast to the opposite effect of contraction of fibrous tissue with an enclosed open cavity. When tuberculous disease heals by resolution, the elasticity of the lung is not lost and fibrosis is minimal. The elastic pull of the lung considerably enlarges the cavity. When there is a fibrous walled cavity with surrounding fibrosis, the contraction or pull is in the opposite direction. Figure 8 shows diagrammatically the two effects.

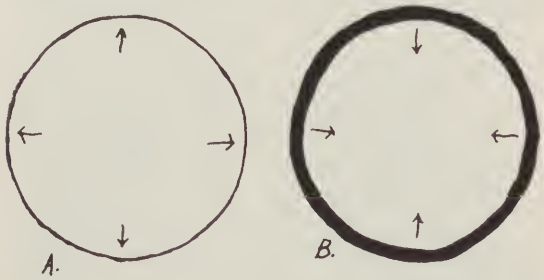


FIGURE 8—A. The cystic like cavity which is not surrounded by fibrosis and contains none in the cavity wall, is expanded by the elastic pull of the lung. B. The fibrous walled cavity surrounded by fibrosis is contracted in the opposite direction.

It will be noted from the Tables that no bronchiectasis occurred in the blocked and partially blocked cavity cases. This may be more than coincidental. It may mean that these bronchi are more resistant to tuberculosis and the development of bronchiectasis. It is further noted that spread of tuberculosis is slower and more limited in these cases. Figure 2 suggests that bronchiectasis is not an end product of tuberculosis as a result of contraction of old scar tissue, but takes place in the earlier disease which does not heal by resolution and in those patients whose bronchi are susceptible to a destructive tuberculous process.

Figures 2 through 4 suggest that cavitary tuberculosis may follow a pattern. This, theoretically, would go through the following cycle. An original cavity with a single bronchial opening is present. As the cavity increases in size, the lobe or lung contracts. Disease invades and destroys other bronchi and other cavities coalesce with the first and the cavity now has multiple bronchial openings. As this continues, multiple bronchi slough off, with further destruction, until again the cavity has one opening. It appears from Table IV and Figures 2 through 4 that in cavitary tuberculosis some bronchi are more susceptible to destruction as evidenced by bronchiectasis and bronchial destruction. Some are more resistant, as indicated by stenotic or healed bronchi and sinus tracts extending from the cavities in an attempt to find a discharge point. The surgical complications of broncho-pleural fistulae in the open cavities further emphasizes the susceptibility of these bronchi. It is significant that more than twice as many broncho-pleural fistulae developed in the open cavity cases than in the blocked. Rich[9] discussed differences of the native resistance and susceptibility of the various organs and included the lungs as one of the most susceptible to tuberculosis. He did not classify bronchial tissue as to its resistance or susceptibility. It would also appear that the bronchus plays a role in dissemination or preventing dissemination of tuberculosis.

Conclusions and Summary

1. There are three categories of cavities: open, partially blocked and blocked. Open cavities appear much more frequently than blocked and partially blocked cavities.
2. Bronchiectasis is the most frequent structural change associated with open cavities.
3. Tuberculous sinuses occur eight times more frequently in blocked cavities than in open, when non-tuberculosis and post resectional cavities are eliminated.
4. A superstructure of dense pleural adhesions which suspends a cavity and hinders the

contraction of underlying scar tissue prevents cavity closure. A partial obstruction prevents cavity closure.

5. The mechanisms of the closure and the nonclosure of cavities were discussed.
6. Cavitary studies are helpful in demonstrating cavities suspected but not previously demonstrated.
7. The bronchi in different individuals show differences in resistance to a destructive tuberculous process.
8. The bronchi play a role in disseminating or preventing dissemination of tuberculosis.

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Diagnosis of Lymphoma by Marrow Aspiration: Value of Histologic Sections*

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Four cases of malignant lymphoma diagnosed by histologic sections of bone marrow aspirate are presented. In two instances clinical features were insignificant and marrow study to explain anemia revealed lymphomatous involvement.

BONE marrow involvement by malignant lymphomas is not uncommon and may be either primary[8,9,11] or secondary. Consequently it is possible to diagnose such lesions by study of marrow aspirate. However, the conventional smear often fails to prove a known or suspected[2,3,10,16] case. Only with the advent of paraffin section preparations of bone marrow aspirate has the definitive histologic diagnosis of medullary lymphomas become practicable. In cases presenting without significant clinical, biochemical or roentgenological findings such a technique may be invaluable.[1,4,6] The following four cases serve to illustrate the efficacy of histologic preparations of bone marrow in the diagnosis of malignant lymphomas. Of special interest is that only two of our cases were clinically obvious while two were clinically unsuspected.

Case Reports

Case I—A 76-year-old white male with chronic congestive heart failure was admitted to the urological service for a prostatectomy. Post-operatively there was profuse hemorrhage checked adequatcly by fulguration. At that time physical examination revealed insignificantly small, shotty, left submandibular, axillary and inguinal nodes. The heart was enlarged and a harsh apical murmur was heard. The liver was palpable 4 fingerbreadths below the right costal margin and was smooth and non-tender. The spleen extended down to the left iliac crest. Laboratory studies showed a normochromic anemia, slightly elevated indirect bilirubin, a four plus cephalin flocculation test, normal thymol turbidity and alkaline phosphatase. A complete gastrointestinal series as well as intravenous pyelograms were within normal limits. Bone marrow sections for investigation of the anemia revealed Hodgkin's disease (Fig. 1).

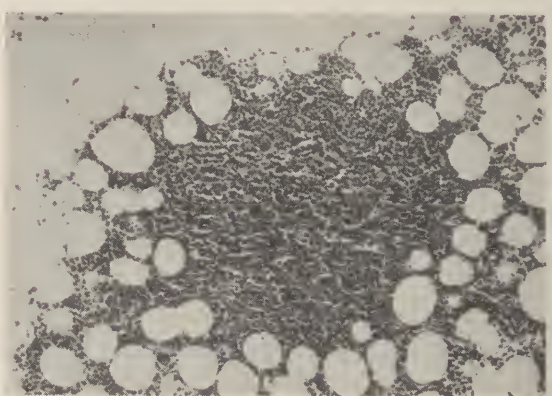


FIGURE 1. Photomicrograph of a nodule of Hodgkin's disease in a paraffin preparation of bone narrow from case 1. Note the large size and irregular outline. The pleomorphic character of the cells in this and case 1 is evident. Surrounding myeloid and erythroid islands appear normocellular. All subsequent photomicrographs are from similar preparations, Hematoxylin and eosin X 100.

His course was ingravescent and he died 18 months following his first admission. Post mortem examination revealed typical Hodgkin's disease involving the bone marrow, spleen, liver, para aortic and hilar nodes. Cervical or inguinal nodes could not be identified.

Case II—A 74-year-old white male was admitted with abdominal pain accompanied by

From the departments of Pathology and Medicine, Huron Road Hospital, Cleveland, Ohio. Doctors Georgi and Nicely are residents in medicine. Doctor Tweeddale is now with the Trover Clinic, Madisonville.

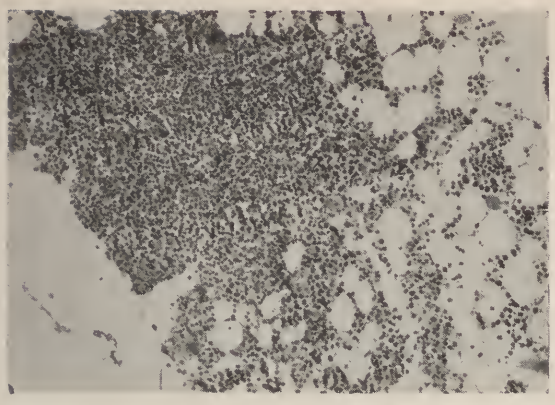


FIGURE 2—A large, irregular nodule of Hodgkin's granuloma from case 2. The associated marrow is somewhat hypocellular. Hematoxylin and eosin. X 100.

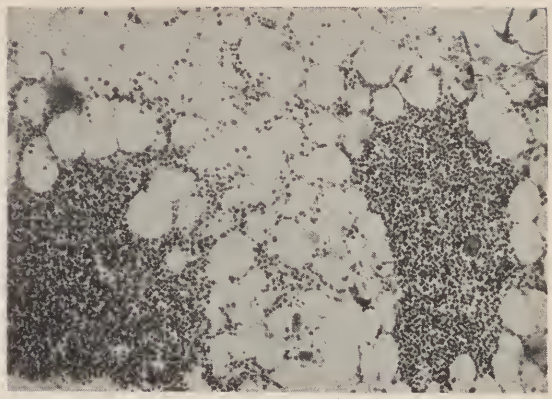


FIGURE 3—Two large irregular nodules of lymphosarcomatous infiltration of marrow from case 4. Even at this magnification the regularity of the cells composing the nodules is obvious. The associated marrow is hypocellular. Hematoxylin and eosin. X 100.

nausea and vomiting. An erythematous rash covered his face and arms. Axillary and inguinal lymphadenopathy was noted. Right upper quadrant tenderness was present but the liver was not enlarged. There was marked splenomegaly which seemed to be the cause for the abdominal pain. An excised node revealed Hodgkin's granuloma. Bone marrow sections disclosed several small nodules of tumor confirming the diagnosis of Hodgkin's granuloma (Fig. 2). There was a satisfactory clinical response to therapy with nitrogen mustard. The anemia present on admission persisted despite the presence of a normocellular, tumor free bone marrow following therapy.

Case III—A 52-year-old white male was admitted because of malaise for one year. One month prior to admission he first had noted lymphadenopathy in the right cervical and bilateral axillary regions. He also complained of general discomfort and thoracic pain without radiation. Hepatomegaly (2 fingerbreadths below the right costal margin) was present but the spleen was not palpated. Cervical node biopsy disclosed lymphocytic lymphoma. Subsequent bone marrow aspiration disclosed early lymphomatous infiltration of the marrow similar to that seen in Figure 3.

Case IV—A 60-year-old white female was admitted with nausea and gross hematemesis. Past history included a left mastectomy for carcinoma 7 years prior to admission. Splenomegaly had been noted by the family physician 10 months previously. No lymphadenopathy was apparent on physical examination. The heart was enlarged and there was a harsh apical murmur. Examination of the abdomen disclosed marked hepatosplenomegaly and minimal epigastric tenderness. A rectal fistula was found. The admission hemogram showed: 7.0 gms. hemoglobin; hematocrit 24%; 4,770 wbc's with 75% neutrophils, 23% lymphocytes, and 1% each of eosinophils and monocytes and 114,460 platelets/mm.^{3} Stool was positive for occult blood. Total bilirubin was 2.2 mg%. Chest roentgenogram showed a right-sided pleural effusion, a dilated aorta, slight enlargement of the heart, and infiltration of the left upper lobe. A film of the abdomen revealed pyloric obstruction. The EEG was abnormal indicating a possible deep subcortical encephalopathy. To evaluate the cause of the anemia, bone marrow sections were prepared and showed the histological characteristics of lymphocytic lymphoma (Fig. 3).

Discussion

The diagnostic value of simultaneously prepared bone marrow smears and paraffin sections is well recognized.[1,4] While the conventional smear is generally adequate to evaluate most hematological disorders,[1] some conditions cannot be readily detected by this method. Among them are included metastatic malignancy, granulomas, thrombotic thrombocytopenic purpura, lipoidosis and malignant lymphomas.[1,3,5,13] In such instances paraffin marrow sections may be invaluable; this has proved to be especially true with the malignant lymphomas.[7,12]

Clinical marrow involvement in the latter conditions does not parallel that noted on pathologic study.[5,14] For example, Gall and

Mallory[6] reported clinical marrow involvement in 10% of a series of 545 cases of lymphomas which included 174 cases of Hodgkin's disease, 5% of which had marrow manifestations, while Steiner[14] found medullary Hodgkin's disease in 11 of 14 necropsied cases. In none of our cases was there a clinical indication of bone marrow involvement, which emphasizes the dichotomy that may exist between clinical and pathologic bone findings in these diseases. In lymphosarcoma the bone marrow is involved less frequently and usually later than in Hodgkin's disease.[3,17] Variability in percentages of osseus involvement in malignant lymphomas probably reflects disease advancement and thoroughness of examination but to our knowledge no controlled series relating to this problem have been reported. Also, the lymphomas, especially Hodgkin's disease, are not always secondary marrow invaders as instances of primary medullary involvement alone or in combination with similar lesions in the spleen or liver have been substantiated.[5,8,9,11,16]

For example, one of our cases (case 4) had no lymphadenopathy although the liver and spleen were enlarged. In that instance the marrow aspiration done to investigate anemia thought to be secondary to hematemesis, revealed unexpected lymphosarcoma. While the association of anemia and related hematological disorders with Hodgkin's disease is more frequent when marrow involvement is present[2,5,12,15] (especially so in "bone marrow Hodgkin's"[9,11]), that anemia observed in cases of lymphosarcoma may be only slight. The exact relationship between the amount of malignant bone marrow involvement and anemia in either condition has not been determined.

In contrast to our case without detectable lymphadenopathy, three patients had such a finding. In one instance (case 1) the lymph node alterations were so minimal that a lymphoma was not suspected clinically and only by marrow section was such a diagnosis made. Subsequent necropsy confirmed the marrow findings in this case. Both cases 2 and 3 had positive node biopsies for Hodgkin's disease and lymphosarcoma respectively plus positive marrow findings. This demonstrates that even in cases of malignant lymphomas already clinically obvious, it may be possible to establish a definitive diagnosis by first studying the bone marrow and thus circumvent a surgical procedure.

The recognition of lymphomas in paraffin sections of marrow can usually be made with some certainty. However, one must be on guard for "benign lymphocytic aggregations" which may be seen in almost 3% of marrow sections.[12] These nodules, in contrast to the malignant lymphomas, are generally quite small and circumscript, composed of mature lymphocytes and are present in very small numbers (Fig. 4). On occasion unusual metastatic tumors may give rise to confusion although by careful study their nature is usually obvious (Fig. 5). Some small cell metastatic tumors such as neuroblastoma and those of bronchogenic origin may offer a real challenge especially if they show nodular infiltration so characteristic of the lymphomas. Aggregates of multiple myeloma, while often distributed similarly to the malig-

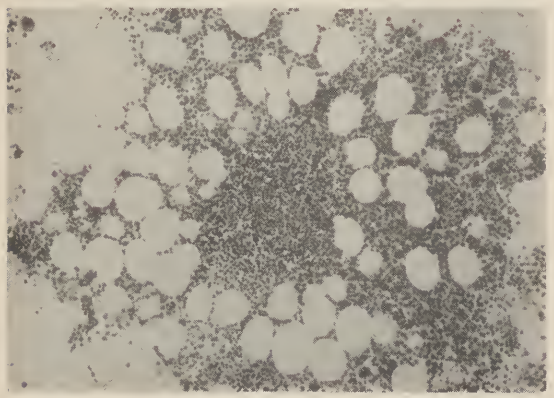


FIGURE 4—A "benign lymphocytic aggregation" found incidentally in the marrow of a patient with unexplained anemia. Note the small size of the nodule in contrast to those lesions previously depicted. The associated marrow is normocellular. Hematoxylin and eosin. X 100.

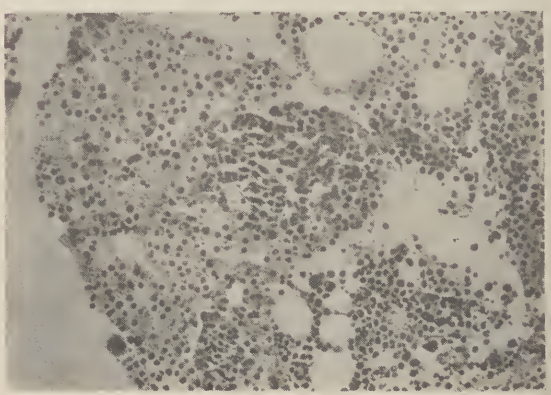


FIGURE 5—There is a small nodule of irregular cells in the center of the photomicrograph. These represent bone marrow spread of synovial sarcoma. This tumor was scattered diffusely but occurred in much smaller clumps than in the lymphomas. Hematoxylin and eosin. X 128.

nant lymphomas, have such characteristic cellular structure that recognition is usually prompt. The appearance of leukemia is as a diffuse sheet of cells quite unlike the nodular character of the lymphomas.

Summary

Four cases are presented to demonstrate the efficacy of paraffin sections of bone marrow in the diagnosis of malignant lymphomas. In two cases clinical features were not diagnostic and marrow study for unexplained anemia revealed the presence of unexpected Hodgkin's disease and lymphosarcoma. It is recommended that the preparation of fixed paraffin sections be a part of every marrow examination.

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Early Operation and Fusion for Scoliosis

The paper is a review of the author's experience with 160 fusion operations in children for the correction of scoliosis. Congenital scoliosis deserves careful watching by serial x-rays and fusion early in life if the curve progresses. The fusion may be very short, with the child ambulatory in a jacket. In paralytic scoliosis, fusion should be deferred to the age of 10 to allow for growth, as paralytic curves are very long. Idiopathic scoliosis in early adolescence should be diagnosed by a standing x-ray; if the curvature is 25° or over, it will progress if growth occurs in the area of the curvature. If the apophysis for the iliac crest has not appeared in the X-ray, growth is certain to occur, and the curve will increase. If the curve is allowed to progress with growth, deformity of the rib cage, present in the dorsal curves, will persist after the correction and fusion. The LeMesurier hammock, in which the jacket is applied in a corrected position is recommended. Follow-up showed that, in idiopathic scoliosis in the adolescent between the ages of 10 and 12, fusions resulted in clinically straight vertebral columns with no prominent rib cages. In older children a fair degree of scoliosis persisted, as did the rib-cage prominence, despite all attempts at correction and fusion.
W. T. Mustard, Canad Med Ass J—Vol. 84:1365 (june 17) 1961

Keratoacanthoma*

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Keratoacanthomas, virus type skin lesions generally occurring on the hands and arms of older patients, simulate skin carcinoma and have often been mistaken for it. Diagnosis requires microscopic examination.

THIS is a report of a review of fifty cases of keratoacanthoma selected from clinical and surgical pathology files collected over a recent three-year period.

Definition

Keratoacanthomas are benign skin tumors which simulate low-grade invasive squamous cell carcinoma. There are many synonyms, the most dramatic of which is "self-healing carcinoma of the skin." These tumors have been sporadically recognized as such for 60 years in the medical literature, but only during the 1950's have variants of the lesion become consolidated and established into a common histopathological entity.[1,2] In preparing this paper we had intended to review and summarize the entire literature. However, we learned that this had already been done well, if infrequently, before. The best of the reviews we nearly overlooked, because it is in a small recent monograph,[3] rather than in a key periodical.

It is exciting to recall with J. S. Dunn and Ferguson Smith[4] that originally, when it was thought that these lesions were true squamous cell carcinomas that healed spontaneously, there was a great deal of wishful enthusiasm based on the hopes that should the self-healing process be understood, a new approach to the cancer problem would be revealed. Since then, however, we think it has more correctly come to be believed that these lesions are not true neoplasms and that they are self-limited from the onset and lack the critical built-in factor of progressive growth necessary for a lesion to be defined as a true neoplasm. It is recalled that Willis' definition of a true neoplasm includes the quality of irreversibility of growth.

Nevertheless, the lesions continue to simulate well-differentiated, squamous cell carcinoma, and the converse is equally true. There is no way of estimating how often the two are confused, but it might be imagined that in the past it has been a very common error. Undoubtedly, these so-called self-healing carcinomas have accounted for cures by miraculous or witchcraft methods. Within recent months, we have seen a patient reputedly cured of a skin carcinoma by application of a natural mud dispensed by a local "medicine man." This case was not scientifically documented, but in light of previous erroneous concepts of keratoacanthomas it could well have been.

Description

As mentioned above, there are many synonyms for the lesion—self-healing squamous cell carcinoma, pseudoepitheliomatous hyperplasia, mulloscum sebaceum, benign acanthosis, etc. The term keratoacanthoma was first suggested by Frudenthal.[3] It is the most accurate term because the principal histopathology consists of an interplay between proliferation and keratinization of squamous epithelium (Fig.1). There is squamous cell papillomatous hyperplasia. This papilloma has a central keratin core around which there is marked acanthosis or proliferation of the prickle cell epithelium.

*Presented before the Kentucky Society of Pathologists, September 22, 1960, at the 1960 Annual Meeting of the Kentucky State Medical Association in Louisville, Ky.

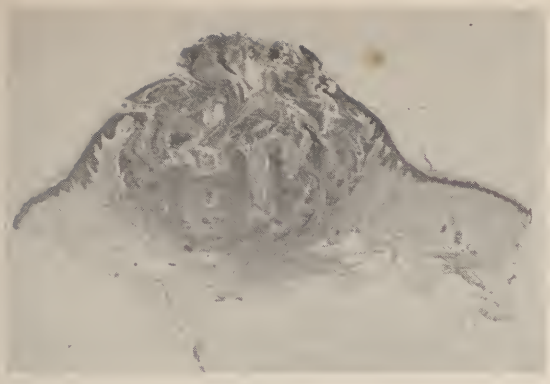


Figure 1.



Figure 2.

Some of its apparent invasion is due to displacement downward and lateralward of the upper part of the corium, including the sweat glands. This, in turn, causes the surrounding normal epithelium to be stretched over the edges of the inverted cup to give the cup a smooth, thin rim.

Microscopically, the central keratosis and the peripheral acanthosis tend to lose their precise pattern, and intraepidermal inclusions of cornified cells and keratin pearls become a prominent feature.

The peripherally growing cells, the ones that simulate carcinoma, are invasive but do not grow ectopically. Often, there is a great deal of mitotic activity and some of the mitotic figures may be atypical or bizarre in construction. Indeed, the actively, even wildly growing peripheral squamous cells and the benign central keratinization is the most widely used diagnostic pivot.

Diagnosis

It is the consensus that though the lesions can be suspected clinically the diagnosis is a histopathological one.

Clinically, the tumors usually develop on the exposed parts of the skin, generally on the face, neck and the exposed surfaces of the upper extremities (Fig. 2). They have been reported as sometimes multiple but usually single. The most striking reports have been of cases that have been followed long enough to be observed to be self-limiting and self-healing. By necessity, the lesions described here in this paper were seen as excised pathology specimens and are not the ones that have healed although the histological details of many cases show evidence of a healing process to be in progress. In typical clinical cases, the lesions progress rapidly, growing from no previous lesion at all to become 1 to 3 cms. in diameter in a time lapse of 2 to 8 weeks. After this, they typically lie dormant and then regress. In contrast to true squamous cell carcinomas, they are incapable of metastasis. The true carcinomas grow slower and are more likely to occur in skin already preconditioned to malignancy by chronic degenerative dermatoses.

It has been generally suspected by analogy that the lesions are due to a virus. Indeed, the lesions are clinically and microscopically not dissimilar from those of m u l l o s c u m contagiosum, plantar warts, and other virus-caused papillomas.

The best evidence of their viral etiology has been reported by Ereaux, Schoppeocher and Fournier.[5] They reported, "Inoculation of tissue from the skin lesion of the chorioallantoic membranes of the chick embryo resulted in focal lesions on the membranes times five passages. Electron miscroscope studies were made and photographs showed brick shaped particles which resembled the molluscum contagiosum virus but three times smaller."

Discussion of Series

The list of fifty cases of keratoacanthomas that we have collected does include early examples of keratoacanthoma, but it does not include controversial examples where the diagnosis of squamous cell carcinoma has not been excluded. Certainly not all of these lesions would have in previous years been called squamous cell carcinoma. Some of them would probably have been called benign inverted p a p i l l o m a or perhaps variants of benign pseudoepitheliomatous hyperplasia. Undoubtedly, on the other hand, many of them would

have been called invasive squamous cell carcinoma, grade 1.

Thirty-three, or 66 per cent, of these cases were in males. The literature in general indicates that the males predominate.

The youngest patient in this series was 32-years-old and the oldest patient 81-years-old. The average age was 51.5 years. The age was not stated in thirteen cases. In 23 of the 37 cases, where stated, the age was 60 or over.

The size of the lesions ranged from .5 cm. to 3.5 cms. Eighty-two per cent of the lesions were in the range of 1 to 1.5 cms. in diameter.

Twenty-six of the fifty lesions were described as being on the dorsum of the finger, hand, or wrist. Eight of the lesions were on the dorsum of the arm; presumably the forearm or between the elbow and the wrist. Seven of the lesions were on the face, including the nose. Four of the lesions were on the neck, and there was one each on the shoulder, leg, heel and scrotum. The sites of the other lesions were not stated. In this group, forty-seven of the cases were single lesions and three were multiple. None of the cases has been reported as having a recurrent lesion either at the primary site or at a metastatic site. All of the cases have occurred six months to forty-two months previous to this report.

Summary

In summary then, we have reported fifty cases of keratoacanthoma collected over a recent three-year period. The lesions have occurred generally on the dorsum of the hands and arms, and on the face and neck. They have predominated 2:1 in males. Generally, the patients have been 60 years of age or over. This is a relatively new diagnosis with us and it has been made with increasing frequency and confidence.

It is anticipated that a high index of suspicion will reveal many of these lesions in pathology and dermatological practices. By the same token, one should be warned that the same high index of suspicion should not lead to the misdiagnosis of keratoacanthoma in cases of true invasive squamous cell carcinoma.

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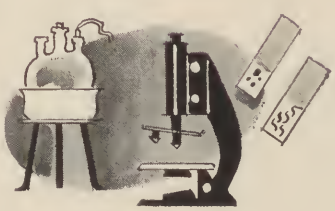
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The Changing Philosophy of The Doctor in Court*

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Winston-Salem, N.C.

Since sixty-five to eighty per cent of all litigations today require medical reports or testimony in court, the role of the physician is becoming increasingly important.

IT is my feeling that this subject is worth exploring, in view of the increasing frequency with which doctors in general, and orthopedic and neurosurgeons in particular, find themselves subpoened to pre-trial hearings and court trials, in the interest of the administration of justice. It has been estimated that from sixty-five to eighty percent of all litigation in our courts today reguires some type of medical report or testimony, and seven out of ten personal injury cases are decided on medical, rather than legal considerations. And further, that fifty to sixty percent of all cases, coming to trial, involve personal injury.

Many physicians, hold the concept that by his appearance in court, amid the wranglings, numerous objections, and brow beatings of the opposing attorneys, the doctor is actually aiding and abetting more in the miscarriage of justice than its administration. Fortunately the snide and uncouth type of lawyer went out with the five cent cigar, the pompadour and the bustle. No longer are medical witnesses asked if they have stopped beating their wives, how much they are being paid for testifying, or how much they charge for the medical lecture they have just given the jury. They have been replaced by the more thoughtful and courteous lawyer, who honestly tries to save the medical witness as much time as possible in a court appearance. "Better manners" on the part of both doctors and lawyers has improved our interprofessional relationship to a marked degree.

If we will adopt the attitude that medical reports to attorneys and occasional court appearances are a necessary and often mandatory requirement in the discharge of our duty to our patients, and will not leave the impression that we are "hard to get" it is my opinion that we will fare much better in the eyes of the public, whom we have been licensed to serve.

The courtroom is truly a showcase for the medical witness for there he is on display, and all facets of his makeup are brought out, scientific knowledge, honesty, judgement and integrity. As medical witnesses we do not go into court to win the case. Our duty is to give factual information with complete honesty and no semblance of bias or advocacy which would influence or flavor our testimony.

I personally object to our being designated as an expert witness, and I have the feeling that "professional witness" would put us all more at ease and be more in keeping with the honest concept that no man is a final authority in medicine. As I recall, the old threadbare definition of an expert on any subject, is just an ordinary fellow some distance from his home town. The atomic age definition, I believe, is this: The X is an unknown quantity, and the spurt is simply a big drip under pressure.

Man is very apt to fear that which he does not understand, and certainly the average doctor has difficulty understanding the modus operandi of the trial court.

Approaches to Truth

There is a fundamental difference in the

*Presented before the Kentucky Orthopedic Society at the 1960 Annual Meeting of the Kentucky State Medical Society in Louisville, Ky.

method of approach of law and medicine, so far as the discovery of truth is concerned. The lawyer attempts to maintain his position by argument and contention with opposing counsel. His professional life is one of advocacy of causes, his object is to magnify his own argument and belittle those of his opponents. The physician, on the other hand, does not live by contention. His training was in the free and open atmosphere of laboratory, hospital, sick room and private office. He demands full and free discussion of all phases of the case, and after careful physical examination and pertinent laboratory studies, forms a judgment, with reference to the illness or injury.

By training and practice, the whole tempo and attitude of the day to day experience of the doctor and the lawyer are all totally different. Lawyers accept as a matter of course, the proposition that their opponents will challenge and question their every turn in the course of a litigation. I submit to you that most lawyers equally well recognize, that only by searching inquiry is the truth developed. Basically the medical profession accepts the same principal. No honest, reputable physician accepts as scientific truth the first report on new methods of diagnosis or treatment. He wants to be assured of close checks, re-checks and critical examination of any new concept, drug or pharmaceutical, operative procedure, prosthetic material or appliance, yet many of our colleagues sorely resent incisive examination and cross examination, and take as a personal affront the probing tactics of attorneys in court. Physicians often complain that they are practically made parties to the case in which they are required to testify. Often it appears that the medical witness for the plaintiff is testifying against the defendent, which of course, should not be true. The physician is truly testifying only to a certain set of facts, and should studiously avoid any appearance of bias or advocacy.

Even though it may appear that while one attorney is trying to bring out the truth, the opposing attorney is trying equally hard to keep the truth from being brought before a judge and jury, the doctor witness must bear in mind that these are only tactics, and fortunately will not have to be decided by him, but will fall squarely in the laps of the twelve men in the jury box, with an able assist from the presiding judge.

In the course of several years participation in the inter-professional code committee of my home state Medical Society, I have heard what would appear to be some legitimate gripes from my lawyer friends directed toward our great profession. One of their chief complaints was that of extreme difficulty encountered in getting a medical report from the examining physician. They contend that many physicians do not seem to understand that the medical report is the complete basis for the preparation of the case for either an "out of court settlement" or for bringing the case to trial.

It has been estimated that 50 to 60 per cent of all litigation involves personal injury. Most of the cases involve serious questions of fact concerning alleged injuries of the claimant. In these cases the medical report is an absolute necessity. Complete and factual medical reports will keep the average physician out of court in nine out of ten cases, hence it behooves the "court shy physician" to get his report in promptly, enabling the attorneys to settle the case, and relieve the physician of a court appearance.

Testifying

The law department of our American Medical Association is fortunately becoming more active in familiarizing doctors with courtroom procedures, and the do's and don'ts, which should govern a medical witness.

First, they suggest that there is no real magic about testifying in court. They exhort physicians to remember that a courtroom is a place where practical men are engaged in the serious business of endeavoring to see that justice is done. An honest physician, coming to court to tell the truth, has nothing to fear. Secondly, they recommend that a medical witness not attempt to testify in any area of specialization in which he is not qualified. Thirdly, they suggest that you inform your patient's attorney of all unfavorable as well as favorable facts pertaining to his case. Fourthly, they strongly suggest that the doctor witness be courteous, avoid any semblence of smugness, adopt a modest attitude, and avoid, like the plague, any desire to engage in contentious argument with attorneys. Don't be afraid to admit that your opinion is not conclusive, as it is no admission of ignorance, and do not hesitate to ask per-

mission to qualify any statement or conclusion which seems excessively dogmatic. Avoid terminology which will not be understood by the jury, legal counsel or judge. The role of the medical witness is to explain, not confuse. Keep your dignity at all times in the courtroom. An attorney does not cease to be a gentleman because he questions you in cross examination on your training, experience, your intelligence, your integrity or even your parentage. If his questions seem irrelevant, trust the court and the jury to attach little significance to their importance.

In our teaching program in the Bowman Gray School of Medicine at Wake Forest College, we have attempted to start in the junior year some basic fundamental concepts of the doctors duty to the courts. At the senior class level, we have competent attorneys, who handle Workmen's Compensation and personal liability cases, lecture to the students on court procedures, especially in the realm of medical evidence. Twice a year, the law school of Wake Forest College, conducts moot court trials. A state or federal court judge presides, and the senior law students appear for both the plaintiff and the defendent. The senior house officers of our teaching hospital appear as medical witnesses, and the case is conducted along the strictest of judicial lines. These trials are attended by many of our local bar and medical professions, and we have a feeling that the project has been of tremendous value in bringing about better understanding between our two great professions.

We try to point out to the students and house officers the pitfalls of casual and cursory examination, and inadequate records and preparation of their case, as they will certainly be placed in a very bad light when their findings and opinions are contradicted by someone who has properly prepared himself, and stress that in such a situation, they have no one to blame but themselves. We further exhort these embryo physicians not to let sympathy, friendship nor misplaced loyalty color their testimony, whether consciously or unconsciously, in favor of one side or the other, as they will only serve to discredit the profession and obstruct the proper administration of justice.

Professional Cooperation

Neither law nor medical science is static. Both grow daily, and as they grow, each supplements the other. Despite amazing progress, both professions have much remaining to accomplish. The medical profession comes to the law with its knowledge and information. The law brings to medicine its problems and hopes. A realization and appreciation that each of the great professions can assist the other, is perhaps the first step towards inter-professional co-operation.

In closing, may I leave with you an object lesson, which might be of some benefit if you should find yourself on the witness stand, with some doubt in your mind as to the manner in which you should proceed. As the story goes, a fish fry was being held down in the deep South, and was attended by a rather large segment of the population. A rather serious difference of opinion arose between two of the brethren, and a "social razor" suddenly appeared and was laid rather forcefully against the region of the jugular vein and carotid sheath of one of the brethren. The wielder of the razor was formally indicted for murder and later brought to trial. It seems there was only one eye-witness to the murder, and after being duly sworn, this witness was placed on the stand and asked to testify as to what he knew about the killing. Thus began his testimony: "Bright and early on Tuesday morning, me and the old woman got up, and she fixed breakfast and us et. After breakfast, I throwed some cold taters and corn pone in a poke and headed up to the field where I was gonna' work. When I got to the big road, I met Mose, and I said, "Mose," and then, of course, the attorney for the defense said, "I object, he can only testify as to what he knows about the murder, and cannot testify as to what he said to anyone or to what anyone said to him." The judge immediately sustained the objection, and the witness was instructed to proceed with only the facts, as he knew them, relating to the murder. The witness began again: "On Tuesday morning bright and early, me and the old woman got up early, she fixed breakfast and us et. After breakfast, I throwed some cold taters and corn pone in a poke and headed off to

the field where I was gonna work. When I got to the big road, I met Mose, and I said, "Mose," and the attorney for the defense again strongly objected, and the objection was of course sustained by the judge. The witness was again asked to testify only to facts, as he knew them, about the murder, and this time, he replied, "Folks, let me make a deal with you. If the gentleman out there that is asking all the questions and the other gentleman that is objecting to all the questions," and turning to the judge, "and you, setting up there with the long black robe on, that is sustaining all the objections to the questions, if the three of you will hold your tongues for about five minutes, before the Lord, I will try my best to divide the truth about this killing just as nigh between you as I kin."

Perhaps that is what we should do as medical witnesses, try to divide the truth between the plaintiff and defendent just as nigh as we kin.

Cardiac Arrhythmias Following Intracardiac Surgery

Records of the 211 patients undergoing cardiac surgery from January 1959 through November 1959, at the Hahnemann Medical College and Hospital in Philadelphia, were reviewed. Serious postoperative arrhythmias developed in 39 (19%) of these patients. Atrial fibrillation developed in 10 patients, atrial flutter in 4 and atrial tachycardia in 2. Nonparoxysmal nodal tachycardia with incomplete A-V dissociation was seen in 9, with reciprocal rhythm in 2 and with complete A-V dissociation in 2. Ventricular bigeminy occurred in 3 patients with nodal rhythm, and a persistent ventricular bigeminy in 6 other patients. Rapid atrial mechanisms developed in the postoperative period in patients who experienced premature atrial systoles in the preoperative period. Electrocardiograms taken immediately prior to surgery frequency suggested clues to serious postoperative arrhythmias. Open procedures carried out with the aid of hypothermia were more frequently associated with serious arrhythmias. Patients with rapid atrial mechanisms responded to redigitalization. However, if digitalis was withheld because of nonparoxysmal nodal tachycardia, rapid atrial mechanism frequently resulted. More serious problems developed in patients exhibiting evidence of excessive or insufficient digitalis therapy. A persistent ventricular ectopic beat or complete A-V heart block associated with nonparoxysmal nodal tachycardia or ventricular tachycardia was a sinister sign; 5 patients died with these mechanisms. The use of an internal pacemaker with an electrode directly inserted in the myocardium prior to closure of the chest is indicated in these cases. Operations close to the conduction system are another cause of nonparoxysmal nodal tachycardia.

M. D. Rabbino, L. S. Dreigus, and W. Likoff, Amer J Cardiol—Vol 7:681 (May) 1961

Cesarean Section in Breech Presentation

Ali T. Arban, M.D.

Lexington, Ky.

Opinions of several writers regarding Cesarean section in breech presentation are considered and statistics are given regarding breech presentation and risks of vaginal delivery.

THE management of breech presentation requires the highest skill and the application of all the fundamentals of obstetrics because of the high fetal mortality (14%).[4] Years ago, when Cesarean section was an extremely dangerous procedure for the mother, external cephalic version was almost routinely performed to avoid it. With the rising safety of abdominal delivery and our increased tendency to perform the operation for fetal indications, the problem of its use in patients with breech presentation has come under close scrutiny.

I would like to mention some of the latest opinions regarding the problem and attempt to clarify its present state.

Etiological Factors in Breech Presentation

According to Weisman's periodic X-ray studies, prematurity plays a definite causal role.[1] He demonstrated that 24% of fetuses presented by the breech at the 13th to 20th week and that this decreased to 8% by the 28th to the 30th week. By the 38th to 40th week, about 40% of the fetuses underwent spontaneous version.

The cord around the neck, as an important cause of breech presentation has been ignored, yet, if the head and neck are tethered to the placenta, which is normally in the fundus, the breech will present.[2] This theory seemingly well explains the premature separation of the placenta during labor and external versions. If the presentation repeatedly reverts to a breech after versions, the cord around the neck, as a causative factor should be strongly suspected.

Statistics on Breech Presentation

In slightly over 50,000 deliveries at Johns Hopkins, where practically no external versions are performed, Eastman reported an incidence of breech presentation of 2.8%.[4] Despite the claims of many regarding prevention of breech presentations, Grimes et al reported from Georgia, where external version was common, an incidence of 1.9%.[3] Though the difference in the figures is small, it seems to me that a careful, gentle, attempt at version, without anesthesia and analgesia, is wise from the 32nd week, or in selected cases. However, some authors have reported a fetal mortality rate as high as 4% following external version.[5]

Dangers of Breech Presentation

In breech presentations the fetal membranes rupture before cervical dilatation is far advanced in 62% of the cases.[6] Also, prolapse of the cord, a common complication of labor occurs in 5% of the cases. On the other hand, breech presentation is found in approximately 25% of all cases of prolapsed cord.[7] The association of breech presentation with congenital abnormalities has been noted by many. Among 1,705 such malformations studied by Potter and Adair, 26% of the hydrocephalics and 18% of the anencephalics (weighing over 2500 gms) delivered as breech.[8] Last in the list of inherent dangers is the problem of injury to the baby in the course of delivery. The common injuries are: 1. fractures of humerus, clavicle, femur, spine and skull; 2, dislocation of

shoulders and cervical vertebrae; 3. brachial plexus injuries; 4. intracranial hemorrhage; 5. brain damage.

Fetal Risk in Vaginal Delivery of a Breech

In recent years, well trained obstetricians have reported a fetal mortality rate for full term breech deliveries essentially the same as for vertex presentation, namely 0.8 - 2.7%.[9, 10, 11, 12] On the other hand, most writers agree that a vaginal delivery of a breech, even when spontaneous, is a traumatic procedure for the baby. Seeley,[13] in his study of 1,240 breech deliveries found:

	5 lb. 8 oz. to 5 lbs. 15	6 lbs. to 6 lbs. 15	7 lbs. to 7 lbs. 15 oz.	8 lbs. to 8 lbs. 15 oz.	9 lbs and over
	oz. per cent died	oz. per cent died	per cent died	per cent died	per cent died
Primiparas	14.8	7.0	1.4	16.7	50.0
Multiparas	6.1	1.4	3.4	7.3	17.9
All Cases	10.0	4.4	2.5	11.3	20.0

There is general agreement that a trial or test labor in the true sense cannot be used in breech presentation. Hall and Kohl reported a marked increase in perinatal loss if the length of time from rupture of the fetal membranes till delivery exceeded 24 hours.[14] Greenhill noted the tendency to hyper-rotation and hyper-extension of the vertex in breech presentation, but felt that this per se did not call for abdominal delivery.[15] Wilcox studied 216 breeches by X-ray and found vertex flexion in 40%, neutral position in 50% and hyper-extension in 10%.[16] His conclusion was that the preliminary position of the vertex caused no interference with vaginal delivery.

Pitocin Stimulation

Hall and Kohl state, "It seems reasonable, because of the high perinatal loss in the patients who received Pitocin® stimulation, to condemn its use except possibly in selected cases of secondary uterine inertia where there is no indication of disproportion and labor has progressed satisfactorily up to the onset of the inertia.[14]" On the other hand, Thompson advises its use.[17]

It is highly important to obtain X-ray pelvimetry in all cases of breech presentation, even in multiparas, not only to rule out any real pelvic problem, but to attempt to diagnose any congenital abnormalities. Radiologists admit the inaccuracy of their attempts at fetal skull measurements so we are left to our clinical senses in the often critical problem of estimating fetal size.

The following table, compiled by Hall and Kohl, gives the incidence of Cesarean section in a large series:

Weight in gms	Primip. %	Multip. %	Total %
2000-2499	12.5	6.8	8.5
2500-2999	8.8	10.9	10.1
3000-3499	13.5	7.2	9.9
3500-3999	24.6	13.7	18.2
4000-4499	36.3	8.7	17.6
4500-4999	50.0	25.0	33.3
Entire series	12.7	9.5	10.7

Summary and Conclusion

In summary, I would like to give the opinions of several writers regarding Cesarean section in breech presentation. Hall and Kohl state that Cesarean section has the lowest perinatal mortality of the various methods of delivery, but this should not imply that it should be used in all breech deliveries. They recommend the procedure as the method of delivery in the following cases: 1. contracted or borderline pelves; 2. large infants, 3. bad obstetrical history; 4. primigravida over 35 years of age; 5. most cases of uterine inertia; 6. placenta praevia; 7. selected cases of premature separation of the placenta and prolapse of the cord. Greenhill[15] recommends Cesarean section in 1. patients over 35 years old; 2. any degree of pelvic contraction; 3. large baby; 4. complications such as diabetes; 5. patients who have had previous stillbirths. He feels that more Cesarean sections should be done for breech presentation than have been done in the past. Eastman[4] writes that Cesarean section is a safer approach to breech delivery and yields better results for the infant than does a difficult and complicated extraction. It should be freely employed in the presence of pelvic contraction, unduly large infants, uterine inertia, uterine dysfunction and in primigravidas over the age of 35 years.

In conclusion, I feel that often the management of a case of breech presentation would tax the wisdom of a Solomon, but in general a more liberal attitude toward abdominal delivery should be adopted by many of us.

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SPECIAL ARTICLES

New Benefits Will Soon Be Offered To Eligible Members Enrolled In Blue Shield and Blue Cross

FOLLOWING three meetings of intensive study by the KSMA Advisory Commission to Blue Shield, recommendations were made which have been accepted by the Boards of both Blue Shield and Blue Cross and after much work by the staff of the Blue Shield and Blue Cross, a number of new and extended benefits are being jointly offered to members enrolled in eligible Blue Shield and Blue Cross groups.

Joint announcement of these extended benefits was made by John Dickinson, M.D., Glasgow, chairman of the Board of Directors of the Kentucky Physicians Mutual, the Blue Shield Plan for Kentucky, and W. Vinson Pierce, M.D., Covington, chairman of the KSMA Advisory Commission to Blue Shield. Both men express pleasure at being able to offer members of the Kentucky Blue Shield and Blue Cross Plans these added advantages in budgeted medical care. Both Chairmen expressed appreciation for the splendid cooperation of the Blue Shield-Blue Cross staff.

The increased coverage described below has been approved by the Insurance Commissioner of the State of Kentucky, and is now available to the public.

The following services will be available to those members in groups who desire to purchase additional protection, provided required enrollment percentages can be secured and maintained.

A. Extended Benefits Endorsement

Its purpose is to provide long-term care for prolonged illness over and above regular Blue Cross-Blue Shield benefits.

Benefits: In Hospital

—Extends hospital benefits to 730 days.
—Pays 80% of charges for private duty nursing for 30 days (1st day deductible).
—Pays 80% X-ray Therapy and surgical appliances.
—Pays Doctor's hospital visits $3.00 per day beginning 71st day.
—Pays Additional allowances:
  25% additional for all procedures, allowance for which is $200 or more on Preferred Schedule.
  50% additional for all procedures, allowance for which is $100 or more on Standard Schedule.

Following hospitalization

—Pays for doctors' visits $4.00; visiting nurse $3.00 per visit.
—Pays 80% for necessary prescription medications.
—$8.00 per day in approved nursing home or convalescent hospital.
—Pays for 70 insulin shock, 20 electric shock treatments (in or out hospital).
—Pays 80% of X-ray and laboratory examinations or therapy, and psychiatry charges, in excess of first $25.00.

Limitations: Nervous and mental conditions, limited to 120 days. Excluded are pre-existing conditions, maternity, sanitaria and rest cures, services provided by any other group coverage, and all exclusions in basic certificate unless specifically modified.

Lifetime maximum—$10,000.

Group Monthly Rates: (Comprehensive Blue Cross groups only)

	Over Standard Blue Shield	Over Preferred Blue Shield
Single	$1.10	$1.00
Family	$2.25	$2.10

B. Major Medical

This plan is offered only to groups of 50 employees or more that have Comprehensive Blue Cross and either Standard or Preferred Blue Shield.

After payment of the deductible of $100, $200, or $300 (whichever is selected), the plan pays 80% of all reasonable covered medical expenses incurred during a benefit period subject to maximums. This does not affect the payment of the basic benefits paid by Blue Cross-Blue Shield.

Covered Medical Expenses—Covered medical expenses are: hospital charges, reasonable physicians and registered nurses charges, prescription medications, ambulance service, prosthetic appliances, professional physiotherapist.

Benefit Period—The benefit period is 12 consecutive months from onset of illness.

Maximum Benefits—The maximum benefits are:

1. $5,000 per benefit period; $10,000 lifetime; or
2. $10,000 per benefit period; $20,000 lifetime.

Limitations and Exclusions—1. Normal exclusions of the basic Blue Cross-Blue Shield Certificates except where specifically modified. 2. Mental conditions and TB, unless ridered at additional dues. 3. Maternity. 4. Benefits paid under any group insurance contract.

Rates will be determined for each group based upon actuarial factors.

C. In Hospital Medical Benefits

Blue Cross-Blue Shield members who subscribe for this rider will, while confined in a general hospital, receive indemnity for medical services beginning with the 1st day of hospitalization and continuing up to 70 days as follows:

1st day	$15.00
2nd day	10.00
3rd through 10th day	4.00 per day
11th through 70th day	3.00 per day

Medical Service shall be defined as services which do not include:

a. Operative or cutting procedures
b. Treatment of fractures, dislocations
c. O.B. procedures including prenatal or postnatal care

Hospital calls made by the operating surgeon 10 days or less before and 30 days or less after surgery shall be considered a part of the surgical procedures.

Monthly dues				
will be:	Single	$0.45	Family	$0.95
120 days	Single	$0.50	Family	$1.00

D. Home And Office Calls Rider

Office Visit	$4.00
Home Visit	$5.00

Each covered illness—First two visits are deductible (to be paid by the subscriber).

Each accident — No deductible. The maximum is 50 visits each contract year per member.

Excluded are: Prenatal or postnatal care; dental work or treatment; nursing services; medicines; drugs; materials or supplies; medical services in connection with alcoholic conditions; hospital visits; medical services in connection with preparation for or after care of any surgical condition for which allowance is provided by the Blue Shield Certificate of Membership or any other endorsement thereto; services furnished in any clinic or other medical facility operated by or for the federal, state, county, or municipal government or any agency thereof.

Monthly dues are: Single $0.90 Family $3.30

E. New Anaesthesia Endorsement

Up to 20% of the surgical allowance with a minimum of $15.00 (on Preferred Surgical only).

Monthly dues are: Single $0.20 Family $0.55

Many members of Blue Cross-Blue Shield will be interested in various parts of these additional coverages. However, it must be remembered that no member is compelled to purchase any part of the program, as both Blue Cross-Blue Shield are voluntary, and each offers various levels of protection. The more a member is willing to pay each month, the more protection he can provide for himself and his family.

Doctors can make a great contribution to the success of voluntary prepayment plans and especially to their own Blue Shield Plan, which was founded by the State Medical Association to help people budget for their health needs. It is important that they take time to learn

(Continued on Page 930)

EDITORIALS

Our Brother's Keeper

DURING the annual meeting of the American College of Physicians at Bal Harbor, Florida last spring Dr. Jose J. Centurion of Havana, former governor of the College in Cuba but now living in exile in Miami, addressed the meeting of the Regents and Governors. He gave a first-hand and factual account of the events that led him and hundreds of other physicians to leave Cuba and seek refuge in this country. He described in some detail the financial, social, and professional sacrificies made by these physicians when they felt it necessary or were actually compelled to leave their native land and seek asylum in other countries. At that time more than 250 physicians from Cuba were living in exile in the Miami area.

Dr. Centurion described briefly the undertaking of the University of Havana, and in establishing an educational program for Cuban exiles and most particularly the program of the School of Medicine designed for postgraduate education of exiled Cuban physicians. He, a former teacher in the Medical School of the University of Havana, and in good command of the English language, was participating in this teaching program.

Recently we have received from Emil P. Taxay, M.D., Director of the Section of Postgraduate Medical Education in the Department of Medicine, University of Miami School of Medicine, a detailed account of this experiment. Almost 300 physicians who were profoundly depressed and unable to use their time appropriately have been beneficiaries of this program and are being trained to understand and use the English language effectively and to participate either temporarily or permanently in the practice of medicine in this country.

The Department of Health, Education, and Welfare has become interested in this program. The Secretary of the Department, Mr. Abraham Ribicoff, has visited the area to obtain more accurate information regarding its accomplishment.

Various private individuals and organizations have contributed a large sum of money in the form of scholarships or operating expenses for the program. The Pan American Association of Ophthalmologists; the Damon Runyon Cancer Foundation; Johnson & Johnson; Little, Brown & Company; and the S. B. Pennick Company are among those organizations which have given very considerable financial assistance. The program has received acknowledgement and commendation from The Rockefeller Foundation, National Scientific Advisory Council, and the magazines: Newsweek, Life, and the Saturday Evening Post. The Veterans Administration Hospital at Coral Gables, Florida has lent of its personnel and resources. Many physicians in Miami connected with the School of Medicine and some who are not teachers there have contributed substantially and without remuneration.

Doctor Taxey and the University of Miami School of Medicine deserve our commendation and our moral and financial support in such an undertaking of philanthropy and brotherhood. The medical profession of Cuba and the United States will forever be more friendly and understanding in their relations. Some of these men will take back to Cuba a fresh fund of medical understanding and in-

spiration. Some Cuban physicians who will find employment temporarily or permanently in our own institutions will add a measurable amount toward better medical practice in the United States.

We would do well to add our moral, physical and financial support to our fellow physicians in Miami who until now have mostly labored alone.

Sam A. Overstreet, M.D.

About The Author

EMMET Field Horine, M.D., has brought further honor to Kentucky medicine and made another significant contribution to literature of medical history in the publication this year of his most recent book "Daniel Drake, Pioneer Physician of the Midwest." An appraisal of this volume will appear later in the book review section of this Journal.

Doctor Horine, Professor of Medicine for many years and at one time Professor of Medical History at the University of Louisville, was Louisville's first cardiologist, devoting himself exclusively to this specialty since 1924. After an extended study in the United States and abroad, he brought to the University the highest type of clinical teaching in disease of the heart. His clinical work and Dr. John Walter Moore's research in cardiology inspired many of the best students to enter that field and provided for Louisville and Kentucky many exceedingly competent cardiologists.

World War II was a period of trial and unremitting labor for those physicians who continued medical practice outside the armed service. Many of the older physicians in Louisville worked beyond their limits of physical endurance during that period and some undoubtedly sacrificed their lives as truly as if they had died on the field of battle. Doctor Horine, a veteran of World War I, was one of those who carried an exceedingly heavy load from 1941 to 1946. Shortly after the war, when a sufficient number of the younger men returning from service were able to carry on in his chosen specialty, he retired from practice, devoting his time entirely to consultation and farming. It was then that he found time to pursue his chosen avocation, Medical History.

In 1935 he conceived the idea of memorializing a distinguished Kentucky Physician at each annual meeting of the Kentucky State Medical Association. He has since then prepared a biographical sketch, accompanied with the photograph of the subject, for each annual program—thus recording briefly the life and accomplishments of 28 of the prominent figures in Kentucky medicine, the latest sketch being of Doctor R. W. Dunlap, President of the Kentucky Medical Association in 1880. Altogether he has completed 32 such brief biographies. In 1948 he edited "Daniel Drake's Pioneer Life In Kentucky."

For 32 years Doctor Horine has compiled information concerning the subject of his present volume. He has firmly established Doctor Drake among the medical and civic leaders in America of any period. At the time of his funeral in Cincinnati all business was suspended for two hours in his honor. It is claimed that he was the foremost American physician during the two decades prior to his death.

Doctor Drake participated in the promotion of and taught in four medical schools in Cincinnati, Lexington, and Louisville. Much of his energy was spent in a sustained effort to improve the standards of medical education in his day. Physicians concerned with the same problem today will find much in his writings that apply now as aptly as then.

The Author is known for accuracy in his historical writings. He will travel many miles and search out any number of sources to confirm the correctness of a simple statement. It is therefore reassuring to the reader to feel that the material provided him in this book is factual and reasonably unbiased.

Recognizing in Doctor Horine one of her very distinguished alumni, his Alma Mater conferred upon him the honorary degree of Doctor of Letters. He has received many honors in Internal Medicine, in Cardiology, and in Medical Writing. We owe a debt of gratitude for men of his stature and unselfish devotion to our profession.

Sam A. Overstreet, M.D.

ORGANIZATION SECTION

Plans Set For 1961 Annual Meeting

More than 55 speakers will be featured at the Annual Meeting of the Kentucky State Medical Association to be held September 19-21 in Louisville. The Committee on Scientific Assembly and Arrangements urges all KSMA members to review the complete program which appeared in the August issue of The Journal, and to take advantage of the postgraduate education opportunities offered by the 1961 meeting.

Three panel discussions will be presented—one on each day of the meeting. They will be on: "Behavioral Disorders in Children" at 11:10 a.m. on Tuesday, September 19; "Trauma" at 10:50 a.m. on Wednesday, September 20; and "Clinical Toxicology" at 3:50 p.m. on Thursday, September 21.

Fifteen specialty groups will hold scientific sessions on Tuesday afternoon, September 19, and Thursday morning, September 21. All members and guests are urged to attend as many of these groups as desired and are free to move from one to another while they are meeting.

The President's Luncheon at 11:50 a.m. on Wednesday, September 20, will feature T. C. Petersen speaking on "This Too Is The Practice of Medicine." Mr. Petersen, of the American Farm Bureau Federation, Chicago, Ill., is much in demand as a speaker and has appeared before several other State Medical meetings.

Appearances by Edward R. Annis, M.D., will be "extra-curricular" highlights. Doctor Annis is a Miami, Fla., surgeon whose debate with Senator Hubert Humphrey on the King-Anderson Bill received wide acclaim. He will speak at a Kiwanis luncheon and again at an open meeting in the Flag Room of the Kentucky Hotel at 8 p.m. on Thursday, September 21. This event is sponsored by the Jefferson County Medical Society with the close cooperation of the KSMA.

Other features connected with the three-day meeting are: the New Members Luncheon on September 19 at the Brown Hotel; University of Louisville Alumni Reunions; and the Kentucky State Medical Golf Association tournament at Standard Country Club.

In addition, the House of Delegates will hold two sessions. The first will be on Monday night, September 18, and the second on Wednesday night, September 20. The Woman's Auxiliary of the KSMA will meet simultaneously at the Brown Hotel.

The program for the Annual Meeting of the Kentucky State Medical Medical Association has been accepted for 12 hours of Category I Credit by the American Academy of General Practice.

Dr. Larson To Speak At Blue Shield Conference

The Blue Shield Annual Program Conference will be held October 23-24 in Chicago. The Conference, under the sponsorship of the National Association of Blue Shield Plans, will have AMA President Leonard W. Larson, M.D., as one of the featured speakers.

More than 400 delegates, including state and local medical society officers and secretaries, physician-trustees, and executives of Blue Shield Plans, will hear Doctor Larson speak on "Securing the Traditions of American Medicine."

The theme for the two-day meeting is "New Dimensions for Progress." Conference discussions are aimed at explaining and evaluating the basic requirements to be met in promoting the development and growth of Blue Shield to conform to the broadest range of public and professional needs and interests.

1961 Diabetes Detection Drive To Be November 12-18

The annual Diabetes Detection and Education Drive is set for the week of November 12-18. It is being sponsored for the 11th year by the KSMA in cooperation with the American Diabetes Association.

Robert S. Tillett, M.D., chairman of the KSMA Diabetes Committee urges all doctors to participate in the program and check urine samples free for the week of the drive. Last year approximately 55,000 free tests were made and 857 proved cases were reported. Approximately 1600 previously unknown diabetics have been found since the first drive began in 1951.

The KSMA has asked each of its component county societies to name Diabetes Committees for local implementation of the drive. Members of the KSMA Committee besides Doctor Tillett, are: Richard E. Davis, M.D., Central City; Lewis Dickinson, M.D., Glasgow; Frank H. Moore, M.D., Bowling Green; and John H. Willard, M.D., Harlan.

AMA Clinical Meeting Set Nov. 26-30 At Denver

The 15th annual clinical meeting of the American Medical Association will be held November 26-30 at Denver, with a scientific program which will emphasize new research developments. Some highlights will include sessions and papers on such important areas of medicine as genes and chromosomes, electronics and computers in medicine, space medicine, medical aspects of American habits, new developments in

virology, treatment of radiation injuries, new findings in chemotherapy for cancer and latest data in the field of antibodies and antigens.

Marshall Brucer, M.D., chairman of the medical division, Oak Ridge Institute of Nuclear Studies, Oak Ridge, Tenn., will be chairman of a section of internationally known experts in the treatment of radiation injuries. Other well-known participants in the meeting will include A. H. Schwichtenberg, M.D., head of the department of aero-space medicine, Lovelace Foundation for Medical Education and Research, Albuquerque, N. M.; and Jonas E. Salk, M.D., Pittsburgh, originator of the killed virus polio vaccine.

Samuel P. Newman, M.D., Denver, chairman of the AMA's Council on Scientific Assembly, announced confidence that the 15th annual clinical meeting will offer one of the most interesting and informative programs ever presented at the winter session. He said, "The meeting is designed to assist the physician in his practice and will be of great value to the clinician in advancing his knowledge."

Mrs. Roles To Serve On New Political Action Committee

Mrs. Earl W. Roles, Prospect, president of the Woman's Auxiliary to the KSMA, has been named the only woman to serve on the new American Medical Political Action Committee.



Mrs. Roles

The committee, which will act outside of and apart from the AMA, will help medical men organize for more effective participation in political and government affairs. Membership will be open to all licensed physicians who want to join, plus their spouses and adult members of their families.

Gunnar Gundersen, M.D., LaCrosse, Wis., a former president of the AMA, is chairman of the new group. In an Associated Press article, Doctor Gundersen commented that, "other organizations, such as the A.F.L.-C.I.O. Committee on Political Education and other groups of similar purpose, have been functioning for a number of years." He said that AMPAC, which will be voluntary and bipartisan, will help form state and local political committees, provide them with information and aid voter-registration drives and get-out-the-vote campaigns.

Mrs. Roles commented that the principle purpose of the committee will be educational. Activity of the group will be with doctors themselves, she said, as well as with the public in order to better clarify the AMA point of view.

Other members of the committee's board of directors besides Doctor Gundersen and Mrs. Roles are: Milton Davis, M.D., Dallas, Texas, who will be secretary-treasurer; Frank Coleman, M.D., Des Moines, Iowa; George Lawrence, Jr., M.D., Flushing, N. Y.; Donald E. Wood, M.D., Indianapolis, Ind.; and Dan Kilroy, M.D., Sacramento.

'Renal' Symposium Scheduled For October Journal

The fourth annual Scientific Symposium scheduled for the October issue of The Journal is on "Some Recent Advances in Renal Disease." Previous symposiums were on "Diabetes," "Carcinoma of the Lung," and "Selected Aspects of Gastroenterology in General Medicine."

Special editor of this year's symposium is Edmund D. Pellegrino, M.D., professor and chairman of the Department of Medicine of the University of Kentucky Medical Center, Lexington.

Doctor Pellegrino announces that the symposium will carry the following articles:

The Streptococcus and Kidney Disease by Kingsley M. Stevens, M.D., Lexington.

Some Comments on Percutaneous Punch Biopsy of the Kidney by W. B. Stewart, M.D., Lexington.

The Edema of Acute Glomerulonephritis by Thorton Scott, M.D., Lexington

The Physiological Foundation of Diuretic Therapy by William A. Brodsky, M.D., and Gaspar Carrasquer, M.D., Louisville

Renal Function In Hypertension and Its Relation To Antihypertensive Drug Therapy by Leonard Leight, M.D., and Ian Scott, M.D., Louisville

Nephrocalcinosis by William W. Winternitz, M.D., Lexington

A General Consideration of Pyelonephritis; Recent Advances by Arthur White, M.D., Louisville.

Lexington Clinic Sets Program For Fall Conference

The Lexington Clinic has released the program for its Sixth Annual Fall Clinical Conference, to be held at the Campbell House in Lexington, October 27. The one-day conference will begin with registration at 9 a.m. The program follows:

Symposium on Pelvic Cancer,—"A Present Day Look"
K. D. McGinnis, M.D., Moderator

Diagnostic Procedures in Gynecological Cancer .....C. W. Tarkington, M.D.
Radio-curable Pelvic Lesions and Pallistive X-Ray .....Wesley Farnsley, M.D.
Pelvic Cancer Surgery and Perfusion ..R. D. Floyd, M.D.
Medical Care .....M. J. Brenman, M.D.

Symposium on Pediatric Cardiology—"Common Problems"
A. L. Cornish, M.D., Moderator

The Current Status of Therapy for Acute Rheumatic Fever .....John Githens, M.D.
Congenital Heart Disease Problems in Infancy .....W. T. MacFarlane, M.D.
Surgical Treatment of Congenital Heart Disease: What, When and Where .....J. B. Holloway, M.D.

Luncheon Round-Tables

1. Pelvic Cancer
2. Pediatric Cardiology

The Pateint With the Low BMR ...K. R. Crispell, M.D.

Cutaneous Manifestations of Systemic Disease ..... Robert Kierland, M.D.

Symposium on Practical Therapy
C. H. Fortune, M.D., Moderator

Parkinson's Syndrome ..... L. W. Blakey, M.D.
Burns ..... A. M. Moore, M.D.
Bursitis ..... E. Q. Parr, M.D.
Pulmonary Emphysema ..... W. P. Wharton, M.D.
Acne ..... U. W. Leavell, M.D.
Prostatitis ..... J. R. Cole, M.D.

The program has been submitted for six hours of Category I Credit by the AAGP.

U. K., U. L. Receive Research Grants

Grants have been received from several different sources for research at the medical schools of the Universities of Louisville and Kentucky.

Murray M. Lipton, M.D., University of Louisville, has received a five-year senior research fellowship of the United States Public Health Service totaling about $75,000. The Grant, under the sponsorship of Alex H. Steigman, M.D., is from the National Institute of Allergy and Infectious Diseases.

Robert L. McGeachin, M.D., will do research at the University of Louisville under a $49,000 grant from the National Institute for Arthritis and Metabolic Diseases.

Marie Keeling, M.D., will study rheumatic diseases for a year at the U. of L. under a $3,600 grant from the Kentucky chapter of the Arthritis and Rheumatism Foundation.

The Kentucky Heart Association and its chapters have announced grants of $103,397, including $65,817 for research at both schools. Other grants will aid heart clinics and help toward the purchase of new hospital equipment.

Heart Association research grants to the U. of K. to begin July 1 are to: Morris Scherago, M.D., $4,100; and Edmund D. Pellegrino, M.D., $3,175.

Research grants by the Heart Association to the U. of L. to begin July 1 are to: Joseph P. Holt, M.D. (chair of heart research, $15,900); Maurice M. Best, Jr., M.D., $4,800; Herbert K. Kashiwa, M.D., $2,000; Peter K. Knoefel, M.D., $2,400; Frederick K. Hilton, M.D., $2,590; J. Alex Haller, M.D., $1,320; Robert S. Levy, M.D., $5,522; Charles J. McGaff, M.D., $1,660; Marvin Murray, M.D., $3,450; Hubert C. Pirkle, M.D., $1,500; and Thomas D. Stevenson, M.D., $5,400.

NOTE

To County Society Secretaries and Members

Annual AMA dues will be increased $10 on January 1, 1962, and an additional $10 on January 1, 1963, following action by the AMA House of Delegates in New York, June 26. When this increase becomes effective, the annual dues for active members will be $35 a year in 1962 and $45 in 1963. This is the first AMA dues increase in 12 years.

150 Attend Athletic Injury Conference

Approximately 150 coaches, trainers, physicians and dentists attended the third annual Athletic Injury Prevention Conference. The Conference was held in Lexington, August 12, in conjunction with the University of Kentucky's annual coaching clinic.

It was sponsored by the Kentucky State Medical Association in cooperation with the Kentucky Advisory School Health Council and the U. of K. Athletic Association. The program for the meeting at which Carroll L. Witten, M.D., Louisville, presided, was:

9:00 a.m.	Registration
9:20	Call to Order and Purpose of Meeting—Carroll L. Witten, M.D., Louisville, KSMA
9:25	Official Welcome—Ted Sanford, Commissioner, KHSAA
9:30	"You Gotta Have Heart"—John L. Wolford, M.D., Louisville
9:50	"Don't Punt, Pass"—Owen B. Murphy, Jr., M.D., Lexington
10:10	"Keep That Grin"—James E. Skaggs, D.M.D., Louisville
10:30	"Save Those Joints"—George Gumbert, M.D., Lexington
10:50	Time Out
11:00	Discussion Period—Audience Participation
11:50	Adjournment



A poster illustrating the wearing of a mouth guard is examined at the Athletic Injury Prevention Conference by from left: Ted Sanford, Lexington, Commissioner, Kentucky High School Athletic Association; Richard G. Elliott, M.D., Lexington, KSMA president; and Carroll L. Witten, M.D., Louisville, who presided at the Conference. Much of the discussion at the meeting was concerned with mouth guards which will be required beginning in 1962.

Philip J. Maloney, M.D., serving as a surgeon with the U. S. Public Health Service, is the new director of the Specialty Clinic at Louisville General Hospital. Doctor Maloney, a 1957 graduate of the University of Michigan School of Medicine, took his internship and residency training at Mt. Carmel Hospital, Detroit, Mich.

A 1960 graduate of the University of Louisville School of Medicine, **Jim Tolliver, M.D.,** has opened an office for general practice in Whitesburg. Doctor Tolliver, who interned at St. Elizabeth Hospital, is a native of Seco.

Lexington VA Hospital To Open 50-Bed General Care Unit

The Veterans Administration Hospital in Lexington will begin admitting non-psychiatric patients sometime in October, announces Joseph C. Tatum, M.D., hospital manager. Two 50-bed wards are being remodeled and re-furnished with modern equipment for medical and surgical care.

When the hospital opened in 1932, it provided general hospital care for veterans in Central Kentucky, but was converted to a neuropsychiatric hospital after World War II. Doctor Tatum said the added facilities were needed in Lexington now to relieve crowded conditions at VA hospitals in Louisville and Cincinnati. Fifty beds will be available to psychiatric patients requiring general medical and surgical care, and another 50 beds will be available to non-psychiatric patients.

The new ward is also needed to provide training for medical students, residents and interns under an affiliation agreement with the University of Kentucky Medical School. Members of the Medical College staff will act as consultants at the hospital, and students will "rotate through" for teaching purposes, both general medical and surgical and psychiatric.

Dr. Horine's Biography Of Daniel Drake Is Published

Daniel Drake (1785-1852) Pioneer Physician of the Midwest by Emmet Field Horine, M.D., Brooks, has been published by the University of Pennsylvania Press.

Doctor Horine, KSMA's official historian, has written many other articles and books on medical history. He spent 32 years collecting and studying biographical information about Daniel Drake.

In his preface to the book, Doctor Horine says, "All known books, pamphlets, addresses, and manuscript material by Drake have been consulted. In addition, all extant issues of Cincinnati newspapers from 1800 through 1852 were read. Likewise, the newspapers of Philadelphia, Lexington, and Louisville have been consulted for the periods of Drake's sojourn in those cities."

The University of Pennsylvania Press says that, "In the present volume Dr. Horine has offered a scholarly, well-documented appraisal of Dr. Drake, which is likely to stand for many decades as the definitive work on this great medical pioneer."

An editorial, "About the Author," by Sam A. Overstreet, M.D., appears in this issue of *The Journal,* and a review of Doctor Horine's book will appear at a later date.

Harvyl Boaz Elected By Pharmaceutical Assn.

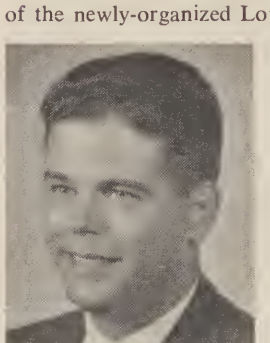
Harvyl Boaz, Paducah, was elected president of the Kentucky Pharmaceutical Association at its meeting in Cincinnati on July 26. Mr. Boaz succeeded J. J. Thompson, South Fort Mitchell, at the meeting at which Governor Bert T. Combs was the featured speaker.

The Kentucky State Medical Association was represented at the meeting by James M. Stevenson, M.D., Brooksville, Chairman of the Board of Trustees.

Other officers elected were: first vice president—Fred Osborne, Ashland; second vice president—Julius Toll, South Fort Mitchell; third vice president—Nathan Kaplin, Louisville; secretary—E. M. Josey, Frankfort; and treasurer—J. P. Arnold, Franklin. Mrs. W. A. Seiler, Paducah; Irvin Kupper, Louisville, and J. J. Thompson were elected to the pharmaceutical association's board of directors.

Dr. Cox To Head New Louisville Mental Health Center

Warren M. Cox, M.D., Louisville, will be Director of the newly-organized Louisville Area Mental Health Center, housed at Norton Memorial Infirmary. The Center is under the joint direction of the Department of Psychiatry of the University of Louisville Medical School and of the Kentucky Department of Mental Health.



Warren M. Cox, M.D.

Doctor Cox previously served as Chief of the Mental Hygiene Consultation Service in the U. S. Army Medical Training Center at Fort Sam Houston, Texas. A native of Evansville, Indiana, he received his medical degree from New York University, served for two years on the medical house staff at Bellevue Hospital, New York City, and took three years of psychiatric residency at Hillside Hospital, Glen Oaks, New York, and at the Brooklyn State Hospital.

Outpatient psychiatric treatment services and a mental health education and consultation program for the area's citizens will be offered by the new Center. Any person in the Louisville area may request services and will be seen by one of the Center's staff members who will, in some instances, make diagnoses and will refer persons to the agencies where they might receive the kind of help they need. It is possible that the Center could eventually serve as a central psychiatric referring agency as well as an educational and treatment center.

NTA Names Dr. Gernert

E. R. Gernert, M.D., Louisville, has been named to the executive committee of the National Tuberculosis Association. He will also serve this year on the Christmas Seal Campaign committee of the NTA. Doctor Gernert, a past president of the Kentucky Tuberculosis Association, has been a member of the boards of the national and state TB associations since 1945.



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U. of K. Medical Center Appoints Dr. Csaky

Among recent appointments made by the Board of Trustees of the University of Kentucky is that of Chairman of the Department of Pharmacology, of the Medical Center. Named as the first member of this new department is Tihamer Zolton Csaky, M.D., professor of pharmacology, who has been serving as an associate professor in the department of pharmacology at the Univesity of North Carolina School of Medicine.

Doctor Csaky was born in Maramarossziget, Hungary, and received his medical training at the University of Budapest and the University of Halle, in Germany. He has also received special scientific training at various institutes in Hungary, and served under Nobel prize winner, Professor A. I. Virtanen, at the Biochemical Institute in Helsinki, Finland. A naturalized citizen of this country, his first position here was as a research associate at the Duke University Medical School.

The University's College of Dentistry has announced that it will receive applications after September 1, 1961, for its class of 1966, which will begin instruction the following September. Beginning in October, 1961, the Committee on Admissions will invite promising candidates to Lexington to meet personally with members of the committee. In full operation, the school will admit approximately 50 students per year.

Safety Commissioner Presents First Jr. Wise Owl Award

Glenn Lovern, Commissioner, Kentucky Department of Public Safety, recently presented Johnny Brooks, Elizabethtown, with a membership in the Junior Wise Owl Clubs of America. The award, presented on Phyllis Knight's "Small Talk" program over WHAS-TV, Louisville, made Johnny the first Kentucky Junior Wise Owl and the fourth nationally.

The Wise Owl Club, for industrial workers whose sight has been saved by protective eye-wear, and its junior affiliate for girls and boys who have been saved from injury or destruction of their sight by safety glasses or other eye protection, are sponsored by the National Society for the Prevention of Blindness. The Society also sponsors Sight Saving Month in September.

The Kentucky Society for the Prevention of Blindness, a division of the national group, recently opened an office at Children's Hospital, Louisville. C. Dwight Townes, M.D., Louisville, is chairman of the advisory committee, and Arthur H. Keeney, M.D., Louisville, chairman of the KSMA Highway Safety Committee, is also a member of the group.

Two Seminars Held in August

The London Seminar of the Kentucky Academy of General Practice held on August 16 at Sue Bennett College, London, was attended by 44 physicians. The program, submitted for five hours of Category I Credit, included the following speakers: Malcolm Barnes, M.D., Louisville; Porter Mayo, M.D., Lexington; Edward Warrick, Jr., M.D., Louisville; Thomas G. Hobb, M.D., Lexington; and Buford Ward, M.D., Birmingham, Ala.

Total attendance at the KAGP's Bluegrass Seminar in Lexington on August 20 was 76. The following speakers participated in the program which was submitted to the AAGP for five hours of Category I Credit: Abe Kuhn, M.D., Dayton, Ohio; Grover B. Sanders, M.D., Louisville; Edmund D. Pellegrino, M.D., Lexington; and James B. Douglas, M.D., Louisville. William R. Willard, M.D., Dean, U. of K. Medical School, was the dinner speaker.

Carroll L. Witten, M.D., Louisville, is the only practicing doctor on a 16-member committee named by the American National Red Cross to rewrite its home-nursing textbook.



Johnny Brooks, Elizabethtown, left, receives membership in the Junior Wise Owl Clubs of America from Glenn Lovern, Commissioner, Kentucky Department of Public Safety. Watching are: Phyllis Knight, WHAS-TV, whose show "Small Talk" was the scene of the presentation, and Arthur H. Keeney, M.D., Louisville, a member of the Advisory Committee to the Kentucky Society for the Prevention of Blindness and chairman of the KSMA Highway Safety Committee.

December Postgraduate Programs Listed

The KSMA Postgraduate Medical Education Office is pleased to announce the acceptance of Jack H. Kamholz, M.D., of the Southwestern Medical School in Dallas, Texas, to give a presentation at the program on Obstetrics & Gynecology planned for Paducah, November 2. Also, for the course on Pulmonary Disease scheduled for October 11 and 12 at Lexington, Samuel Saslaw, M.D., of the Ohio State University School of Medicine, and Jerome F. Wiot, M.D., of the University of Cincinnati have been secured to participate in the program.

Detailed information on these programs may be obtained from the Postgraduate Medical Education Office, 104 West Chestnut Street, Louisville 2. The telephone number is JUniper 7-7135.

The complete listing follows:

SEPTEMBER

Weekly through 1961 One week training in the field of OB & GYN, each week during 1961, with the exception of: October 2-7, and October 23-28; limitation to two physicians per week; fee of $50.00 includes room at Louisville General Hospital, if desired; 42 hours of Category I Credit granted by the AAGP; enrollment should be made at least two weeks before desired participation.

18-23 Post graduate course, "Changing Concepts of Cardio-Pulmonary Disease," Ohio State University, Columbus, Ohio.

19-21 Annual Kentucky State Medical Association Meeting, Louisville.

27-29 Postgraduate Course, "Legal Medicine," University of Tennessee College of Medicine, Memphis, Tennessee.

OCTOBER

3 Postgraduate course, "Medicine," University of North Carolina, to be held at Asheville, N.C., Afternoon and evening sessions.

4 Postgraduate course, "Medicine," University of North Carolina, to be held at Morganton, N.C., Afternoon and evening sessions.

6-8 Central Associational Meeting of Obstetricians and Gynecologists, Cleveland, Ohio.

10 Postgraduate course, "Pediatrics," University of North Carolina, to be held at Asheville, N.C., Afternoon and evening sessions.

11 Postgraduate Course, "Pediatrics," University of North Carolina, to be held at Morganton, N.C., Afternoon and evening sessions.

11-12 Postgraduate course, PULMONARY DISEASES, University of Kentucky, Medical Center, Lexington.

15 Sixth Annual Session on Rheumatic Diseases, Ohio State University, Columbus 10, Ohio.

17 Postgraduate course, "Surgery," University of North Carolina, to be held at Asheville, N.C., Afternoon and evening sessions.

18 Postgraduate course, "Surgery," University of North Carolina, to be held at Morganton, N.C., Afternoon and evening sessions.

19 Postgraduate course, "RECENT ADVANCES IN THERAPEUTICS," Green Meadow Country Club, Pikeville, Kentucky.

19 KAGP Seminar, Maysville, Kentucky.

24 Postgraduate course, "Medicine," University of North Carolina, to be held at Asheville, N.C., Afternoon and evening sessions.

25 Postgraduate course, "Medicine," University of North Carolina, to be held at Morganton, N.C., Afternoon and evening sessions.

25-26 John Walker Moore Seminar, Louisville Society of Internists, Dr. Stuart Graves.

25 KAGP Seminar, Mammoth Cave, Kentucky.

26 Fall Seminar at Our Lady of Peace Hospital, Louisville, Dr. Hollis Johnson, to be held in the auditorium, afternoon and evening sessions.

27 Annual Fall Clinical Conference of the Lexington Clinic, to be held at the Campbell House Hotel in Lexington, Dr. John B. Selby.

30—November 24 Postgraduate course, "Psychiatry," Ohio State University, Columbus 10, Ohio.

31 Postgraduate course, "Medicine," University of North Carolina, to be held at Asheville, N.C., Afternoon and evening sessions.

31-November 2 Postgraduate course, "Advances in Pediatric Diagnosis and Practice," Medical College of Georgia, Augusta, Ga.

NOVEMBER

1 Postgraduate course, "Medicine," University of North Carolina, to be held at Morganton, N.C., Afternoon and evening sessions.

2 Postgraduate course, "OBSTETRICS & GYNECOLOGY," Hotel Ritz, Paducah, Kentucky.

7 Postgraduate course, "Medicine," University of North Carolina, to be held at Asheville, N.C., Afternoon and evening stssions.

8 Postgraduate course, "Medicine," University of North Carolina, to be held at Morganton, N. C., Afternoon and evening sessions.

9 Postgraduate course, "ANESTHESIOLOGY," Louisville General Hospital, Louisville, Kentucky.

9-10 A two-day symposium to be given by the University of North Carolina at Chapel Hill, N.C., general topics have not yet been decided upon at this time.

14-16 Postgraduate course, "Fractures in General Practice," Medical College of Georgia, Augusta, Ga.

(Continued on Page 892)

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A non-profit psychiatric institution, offering modern diagnostic and treatment procedures—insulin, electroshock, psychotherapy, occupational and recreational therapy—for nervous and mental disorders. The Hospital is located in a 75-acre tract, amid the scenic beauties of the Smoky Mountain Range of Western North Carolina, affording exceptional opportunity for physical and emotional rehabilitation. The OUT-PATIENT CLINIC offers diagnostic services and therapeutic treatment for selected cases desiring non-resident care.

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New Isuprel Compound Elixir is a balanced expectorant bronchodilator. It contains potassium iodide to promote expectoration and relieve dry cough. Its three bronchodilators, Isuprel, ephedrine, and theophylline, keep bronchi continuously dilated. Luminal is included to negate possible side effect from adrenergic medication and to provide very mild sedation for the patient.

New Isuprel Compound Elixir alleviates symptoms...prolongs relief in chronic bronchitis and emphysema.

Each good-tasting vanilla-flavored tablespoon (15 cc.) contains:

Isuprel® (brand of isoproterenol) HCl	2.5 mg.
Ephedrine sulfate	12 mg.
Theophylline	45 mg.
Potassium iodide	150 mg.
Luminal® (brand of phenobarbital)	6 mg.
Alcohol	19%

Adult Dose: 2 tablespoons 3 or 4 times daily.

How Supplied: Isuprel Compound Elixir is supplied in bottles of 16 fl. oz.

New ISUPREL® compound ELIXIR

Winthrop LABORATORIES
New York 18, N.Y.

ISUPREL AND LUMINAL, TRADEMARKS REG. U. S. PAT. OFF.

27-30 AMA Clinical Meeting—Denver.

DECEMBER

14 Fourth Annual Norton Memorial Infirmary Seminar, Louisville.

Leo Brown, Jim Reed Promoted by AMA

Leo E. Brown, who has been director of communications for the American Medical Association since 1959, has moved up to a new position as assistant to the executive vice president. Announcing the promotion was F. J. L. Blasingame, M.D., executive vice president of the AMA, who said that Jim Reed, director of press relations and editor of The AMA News, will take over as director of the Communications Division.



Leo E. Brown

Brown joined the AMA staff in December, 1950, as the first executive secretary of the Student American Medical Association. He became public relations director in March, 1951, and director of communications when that division was created in 1959. He has also been a teacher, coach and administrator in Pennsylvania schools and served on the staff of the Erie County Health and Tuberculosis Association and the Pennsylvania State Medical Society.

Reed began the AMA News in June, 1958, after serving more than eight years as editor of the Topeka, Kan., *Daily Capital*. He became AMA director of press relations the first of this year, continuing his duties as editor of the AMA News. He has also served with other midwest newspapers and radio stations. In his new position, Reed will be responsible for supervising and coordinating the AMA's overall communications to the medical profession, to the general public and to communications media.

Doctor Blasingame said the changes were prompted by the need for additional manpower in his office to assist in coordinating and implementing the expanding programs of the Association. Duties of the new position will consist in assisting officers and members of the Board of Trustees and division directors, expanding liaison with various national organizations, representing the executive vice president when necessary and assisting in the administrative duties of the office of the executive vice president.

KSMA New Members Listed

New members of the KSMA since *The Journal's* last report are:

Nicholas W. Glaser, M.D., Louisville
Stanley Hammons, M.D., Manchester
Donal D. O'Sullivan, M.D., Paducah
Gilbert L. Hamilton, M.D., Harlan

While at the Annual Meeting . . . .

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You may be easily reached while attending the KSMA annual sessions, if you leave the **special phone numbers** listed below at your home and office, along with your schedule.

JUniper 3-1933 is the special KSMA number at Columbia Auditorium at the KSMA Headquarters Office, where all general scientific sessions will be held.

JUniper 4-6377 and **JUniper 4-6378** are the special numbers for physicians attending meetings at the First Christian Church. If you plan to attend any of five specialty group sessions or seven reference committee meetings at First Christian Church Tuesday afternoon, September 19—only—Call JU 4-6377 or JU 4-6378.

Or, if you plan to attend any of the five specialty group meetings at the First Christian Church Thursday morning, September 21, only—call JU 4-6377 or JU 4-6378.

Do not call the First Christian Church number! Call either of our official numbers at the Church—JU 4-6377 or JU 4-6378.

JUniper 4-1311 Roof Garden Kitchen extension is the special number to be called if you want to be reached either Monday evening, September 18, or Wednesday evening September 20, while attending the meetings of the KSMA House of Delegates in the Roof Garden of the Brown Hotel.

Digest of the Meeting of the KSMA Board of Trustees

The meeting was called to order shortly before 10 a.m. and was adjourned at 7:45 p.m. All of the members of the Board were present but six and there were 15 guests in attendance. The report of the Kentucky delegation to the 1961 AMA Annual Meeting was given by W. Vinson Pierce, M.D., Fort Thomas. He complimented the new delegate, George F. Brockman, M.D., on his good work at his first meeting.

The Board voted to make the new KSMA Committee on Highway Safety a part of the Council on Communication and Public Service; elected James Davis, M.D., Louisville, to succeed Robert McKinley, M.D., Glasgow, as a member of the KSMA Committee on Postgraduate Medical Education and the scientific program committee; authorized the appointment of a committee to handle surplus property sales that the Association might have in the way of office equipment and voted to pay in advance the transportation of an Annual Meeting guest speaker who had made a special request.

The Board then heard the chairman of the building committee, George Brockman, M.D., Greenville, give an interim report. He stated that the foundations for the new building had been poured, partitions were up in the lower floor and brick was now being applied, and that some steel was being put in place. He brought the Board up to date on the negotiations with the Metropolitan Sewer District for an easement across the front of the property and told of the recommendations that KSMA historian, Emmet F. Horine, M.D., had made. On Doctor Brockman's recommendation, the Board authorized the investment committee—of which Keith P. Smith, M.D., Corbin, is chairman—to borrow whatever funds were needed to complete construction of the building.

At the conclusion of Doctor Brockman's report, Chairman Stevenson explained to the Board that, at the meeting of the Executive Committee of the Board immediately following the ground breaking on May 21, the Executive Committee voted to purchase two additional lots adjacent to the property the Association already owned because it was felt this would protect the Association's investment and provide for possible future expansion. Since the land was appreciating in value, no loss would likely be anticipated. The Board voted without dissent to approve the action of the Executive Committee to purchase the two additional lots at the cost of $6,000 each.

It was explained that under the new bylaws adopted by the House of Delegates at the 1960 Annual Meeting, all councils and committees of councils and standing committees would make their reports, at least six weeks in advance, to the House of Delegates through the Board of Trustees. The Association's legal counsel was called on at this time to suggest uniform procedures for the presentation of these reports and the reporting of the Board's recommendation on each one. It was agreed to follow the counselor's recommendation.

Russell Teague, M.D., state health commissioner, explained that the State Board of Health had passed a resolution calling for the introduction of an amendment to the Medical Practice Act, relating to the liberalizing of the law with respect to foreign graduates. He stated that Carl Fortune, M.D., Lexington, member of the Board and chairman of the committee for this matter, would explain the Board of Health's position. Following lengthy consideration, the Board of Trustees took no action on the matter but authorized the commissioner to send appropriate explanatory materials to all members of the Board at an early date, so that this information could be studied before the Board would again consider the matter at its September 18 meeting.

At this time the Board took up the report of the six councils and the various committees. The reports of the councils and committees were presented by the committee or council chairman of its respective group. Consideration of the reports required four and one-half hours. Action of the Board on each one of these reports will be found at the conclusion of the report that is presented to the KSMA House of Delegates.

The full 19-page minutes of the July 27 meeting are on file in the headquarters office and available to any KSMA member who wishes to read them.

—Time—

Infinitely swift is the flight of time, as they see who look back at it.

—Seneca

Approved Psychiatric Residency for General Practitioners or Others:

"First year appointment beginning July 1, 1962, in well integrated psychiatric training program associated with State University of Iowa Psychiatric Department and the University of Nebraska College of Medicine. Requirements: Must be a citizen of United States or have expressed an intention of becoming one; have completed internship four years prior to July 1, 1962, and have been in practice during that period. Time served in Armed Forces or residency training in some other specialty acceptable. Preference given to applicants under forty-five years of age. Annual stipend $12,000. Applications should be made immediately. Write W. C. Brinegar, M.D., Superintendent, Mental Health Institute, Cherokee, Iowa."

KSMA Committee, Council Reports

Council on Allied Professions and Related Groups

J. Farra VanMeter, M.D., Chairman

Louisville **July 20, 1961**

The Council on Allied Professions and Related Groups held its second meeting of the associational year in Louisville on July 20, 1961.

Primarily, the council heard reports covering the activities of the various committees under the council. Several recommendations from various committees were discussed and passed upon by the council.

The final report of the council was presented to the Board of Trustees at its July 27, 1961, meeting.

KSMA Scholarship Committee

C. C. Howard, M.D., Chairman

Louisville **August 3, 1961**

The Executive Committee of the Rural Kentucky Medical Scholarship Fund met August 3, 1961 in Louisville. The purpose of the meeting was to consider late applicants for loans and to review the progress of the Fund in regard to recipients' moral and financial obligations. The trustees, generally speaking, were well-pleased with the manner in which recipients are meeting both their financial and moral obligations.

Six new applicants were approved for loans at this meeting making a total of twenty-three new loans approved for students entering school this September. This number includes those that were accepted at the May 4 meeting of the Board of Trustees.

Nineteen recipients of the Fund finished their internship this year and twelve of this number entered rural practice, one chose to take a second year of internship and the remaining number are now completing their military obligation.

KSMA Highway Safety Committee

Arthur H. Keeney, M.D., Chairman

Louisville **June 15, 1961**

The first full meeting of the KSMA Highway Safety Committee since its inception was held in Louisville on June 15, 1961, with a 100 per cent attendance.

Response of the survey made among 500 Jefferson County members and the Christian County Society was described and it was felt this was very encouraging. In a 66 per cent reply from Jefferson County, it was noted that 34 per cent of the physicians use seat belts as compared to the national average of three to four per cent. It was agreed that special articles on the survey should be put in the KSMA Journal and that the AMA should also be notified.

The committee heard a report on the Governor's Safety Conference which was held in Lexington on June 13-14, 1961, and also discussed the desire to obtain exhibit space at the Annual Meeting dealing with survival factors.

It was felt that one of the first goals of the committee should be to stimulate interest in a seat belt program, that this activity should first be directed to KSMA members, and that the drive should start at the county Society level. It was the feeling of the committee that the aid of the Woman's Auxiliary should be enlisted in this program.

KSMA Golf Committee

Edwin P. Solomon, M.D., Chairman

Louisville **July 14, 1961**

On July 14, 1961, the KSMA Golf Committee met at the Standard Country Club to formulate final plans for the golf tournament to be held in Louisville during the Annual Meeting, September 19-21.

It was the thinking of the committee that in addition to the traveling trophies, that prizes be given to those winning top honors in the low gross, low net, and senior championship classifications. In addition, daily prizes will be awarded.

Dues for participating in the 1961 tournament will again be $6, which will include the green fees. It was agreed that application blanks should be mailed to those previously participating, and that application blanks also be inserted in the August issue of The Journal.

KSMA School Health Committee

Carroll L. Witten, M.D., Chairman

Lexington **August 12, 1961**

Meeting for the final time during the 1960-61 associational year, the committee discussed the Athletic Injury Prevention Conference which was held earlier in the day. It was felt that the conference had again served a vital function and from all indications could again be considered a success. Approximately 150 attended the third annual conference.

Approval was given to the holding of a similar conference in the western part of the state later on this fall, provided the KHSAA so desires such a conference. It is anticipated this conference will be held in Bowling Green.

Lee Gentry, Supervisor of Health and Physical Education of the State Department of Education was a special guest of the committee and told of the present status of Kentucky schools in their physical education programs. After listening to Mr. Gentry, it was taken by common consent that a resolution endorsing the need of expanded physical education programs in our schools be presented to the House of Delegates at the 1961 session.

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Put your low-back patient back on the payroll

Soma relieves stiffness –stops pain, too

YOUR CONCERN: Rapid relief from pain for your patient. Get him back to his normal activity, fast!

HOW SOMA HELPS: Soma provides direct pain relief while it relaxes muscle spasm.

YOUR RESULTS: With pain relieved, stiffness gone, your patient is soon restored to full activity—often in days instead of weeks.

Kestler reports in controlled study: *Average time for restoring patients to full activity: with Soma, 11.5 days; without Soma, 41 days.* (*J.A.M.A. Vol. 172, No. 18, April 30, 1960.*)

Soma is notably safe. Side effects are rare. Drowsiness may occur, but usually only in higher dosages. Soma is available in 350 mg. tablets. **USUAL DOSAGE: 1 TABLET Q.I.D.**

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Student AMA

Of importance to the new medical student is a certain amount of familiarity and acquaintance with the school in which he is to study. To this end, all forms of descriptive brochures, letters of introduction, and various other missives flood the mail of the prospective student prior to his entry into the university. Much of this serves to add confusion rather than clarification, and only a careful view of the school, its physical plant, its professors, and the advantages it offers can really allay many fears which the new medical student possesses.

This September, entering freshmen at the U. of L. School of Medicine will be greeted by a much enlarged and extended period of orientation. This orientation period will see the new students arriving at the medical school two days earlier than usual, during which time lectures will be given on the History of Medicine in Kentucky and at U. of L., on Study Habits and the use of the Medical Library, and on appropriate textbooks to use. Tours of the Medical Center will be sponsored by upper-classmen; all faculty members and departments will be introduced and the freshmen will get a chance to become better acquainted with their professors at a luncheon on September 9.

The SAMA will sponsor one session with freshmen, designed to present all the different organizations at the medical school and to present the outline of student government as well. During registration on campus, one member of SAMA will talk to the wives of the students about the task that will lie ahead for them as they too become involved in the study of medicine with their husbands. The climax of orientation will be the Dean's picnic on Sunday afternoon for freshmen, faculty, and guests. Many upper-classmen will be present also.

SAMA at U. of L. is happy to have had the opportunity to work with the Dean and his committee in planning this much-improved orientation program. We feel it very necessary to introduce the School and its facilities in a manner new students will appreciate, and from which they will gain a sense of "belonging." The Medical School is to be commended for its effort to prepare its students to effectively meet the strenuous days which lie ahead for them.

Olson Huff, President
U. of L. Chapter SAMA

Colorado Society To Meet

The Annual Session of the Colorado State Medical Society will be combined this year with the Congress on Occupational Health, sponsored by the American Medical Association. The meeting will be held in Denver, October 1-4. Veterinary medicine will highlight one of the meetings and there will be many presentations of interest to general practitioners. For further information, write the Colorado State Medical Society, 835 Republic Building, Denver 2, Colo.

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Sulfadiazine ..... 3.381 gm. (Microcrystalline)
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In a palatable, stable emulsion pleasantly flavored with True Raspberry Flavor. Each average teaspoonful (80 min.) represents .5 gm. (7.7 grs.) of three combined sulfa drugs in suspension. Supplied in pint bottles only.

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In Memoriam

DANIEL LEE BOWER, M.D.
Williamsburg
1899-1961

Daniel Lee Bower, M.D., Williamsburg, died at Baptist Hospital, Corbin, on July 18. Doctor Bower, a native of Medara, Indiana, received his medical degree from Indiana University in 1926. He had practiced in Barbourville before moving to Williamsburg.

D. ELMO McCLURE, M.D.
Elizabethtown
1873-1961

D. Elmo McClure, M.D., an Elizabethtown physician since 1917, died July 27 in Hardin Memorial Hospital where he had been a patient for two weeks. Doctor McClure, a 1906 graduate of the old Hospital College of Medicine, Louisville, had previously practiced in Sonora and Upton. He was 88 and had retired two years ago.

C. E. PALMORE, M.D.
Bowling Green
1897-1961

A 63-year-old Bowling Green physician, C. E. Palmore, M.D., died July 20 at a Louisville hospital following a short illness. A native of Monroe County, Doctor Palmore was a 1922 graduate of the University of Louisville School of Medicine. He represented Warren County in the 1950 General Assembly and was long active in civic affairs and politics on both the state and local levels.

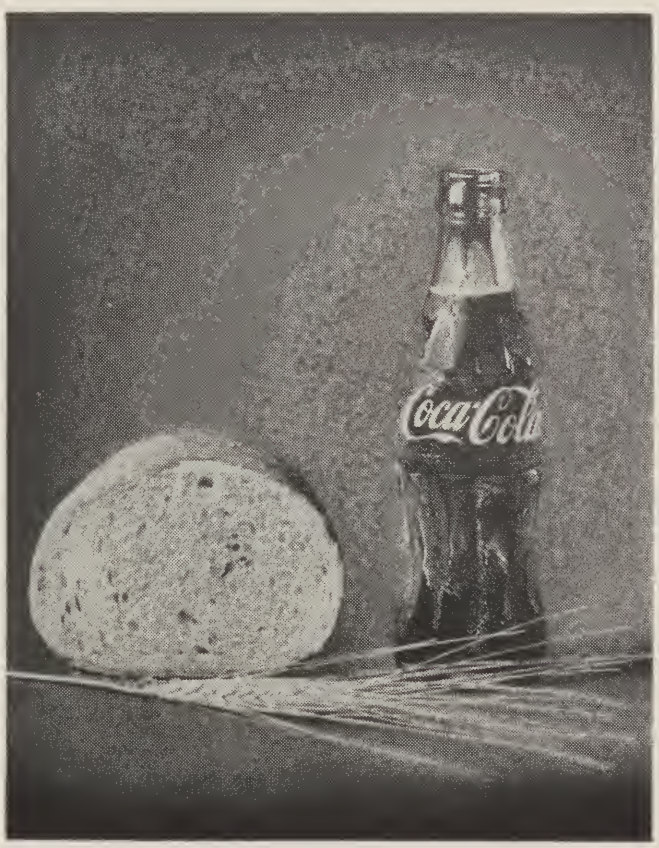
Med. School Changes Name

On July 1, the College of Medical Evangelists, Loma Linda, Calif., officially became Loma Linda University. Since its founding in 1905, curriculums have been offered for the bachelor's degree in five areas, for the degrees in medicine and dentistry, and for advanced degrees in 20 fields. Seventeen additional areas of instruction now become available in the University through the resources of La Sierra College and Pacific Union College.

Industrial Medical Assn. Elects

New officers of the Kentucky Industrial Medical Association for 1961, for one year terms are: president—Charles F. Martin, M.D., Lexington; vice president—Frederick P. Shepherd, M.D., Louisville; and secretary-treasurer—Donald B. Thurber, M.D., Louisville.

Everett C. Wilhite, M.D., became health officer of Kenton County the first of August. Doctor Wilhite received his medical degree from the University of Louisville in 1920.



Coca-Cola, too, has its place in a well balanced diet. As a pure, wholesome drink, it provides a bit of quick energy.. brings you back refreshed after work or play. It contributes to good health by providing a pleasurable moment's pause from the pace of a busy day.

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Seminars Planned by KAGP

The Kentucky Academy of General Practice is planning two Seminars for October. The program for the Maysville Seminar, to be held October 19 is still indefinite. George E. Estill, M.D., Maysville, is chairman.

John C. Ayers, Jr., M.D., Cave City, will be chairman of the Cave Area Seminar to be held at Mammoth Cave on October 25. Senator Thruston B. Morton will be the dinner speaker and scientific speakers will include: William A. Sodeman, M.D., of the Jefferson Medical College, Philadelphia, Pa.; Douglas H. Riddell, M.D., Vanderbilt University, Nashville, Tenn.; and William C. Ellis, M.D., Lexington. The program has been submitted to the AAGP for four hours of Category I Credit.

Gastroenterology Course To Be Held

The American College of Gastroenterology announces that its Annual Course in Postgraduate Gastroenterology will be given in Cleveland, Ohio, October 26-28. The faculty for the Course will be drawn from the Cleveland area medical schools. Subject matter of the Course will be the advances in diagnosis and treatment of gastrointestinal diseases. For further information, write to the American College of Gastroenterology, 33 West 60th Street, New York 23, N. Y.

Oct. Cancer Conference Set

Invitations are being issued to physicians of Western Kentucky, Southern Illinois, Northern Arkansas, Northwestern Tennessee, and Southeastern Missouri to attend the eighth annual Southeast Missouri Cancer Conference. The conference, sponsored by the American Cancer Society, the Missouri State Medical Association, the American Academy of General Practice, and the Cape Girardeau County Medical Society, will be held Sunday, October 8 at Cape Girardeau. Registration will begin at 12:30 and sessions will start at 1:30 and 7:00 p.m.

The first Annual Milwaukee Medical Conference will feature new developments in a variety of medical fields. Fourteen nationally known physicians will participate in the program to be held October 19 and 20 at the Milwaukee County General Hospital. The program is sponsored by the Medical Society of Milwaukee County. For further information write Mr. John C. Kadonsky, Executive Assistant, 756 North Milwaukee Street, Milwaukee 2, Wis.

The Thirteenth Postgraduate Assembly in Endocrinology and Metabolism, under the co-sponsorship of the Endocrine Society and the National Institutes of Health, will be held at Bethesda, Md., from October 2 through 6. A comprehensive review of clinical endocrine problems and current research activity in these areas will be presented. For further information, write to: Roy Hertz, M.D., National Institutes of Health, Building 10, Bethesda 14, Maryland. The fee will be $100 for physicians, with a reduction to $30 for Residents and Fellows. Enrollment is limited to 100.

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For full information write

Louisville Diagnostic Service

R. N. Holbrook, M.D., Director

422 West Florence Ave. Louisville 14, Ky.

Washington News

(Continued from page 840)

tion of the Administration scheme would cost $9 million.

But in May, Doctor Larson said, HEW officials reported the figure as "unrealistically low" and lifted it to "somewhere between $25 million and $255 million."

"Obviously this estimate is something less than precise," Doctor Larson said.

The AMA president said that supporters of the Administration proposal have built their case on five false premises: 1) that the sociological problems of older people can be solved through legislation; 2) that most, if not all, of the aged are in poor health; 3) that most, if not all, of the aged are verging on bankruptcy; 4) that the problem of the aged in financing their health costs will get worse before it gets better, and 5) that voluntary health insurance and prepayment plans, private effort and existing law will not do the job that needs doing.

Wallace E. Combs, M.D., has begun general practice in Nicholasville. A native of Jackson, he is a 1960 graduate of the University of Tennessee Medical School and interned at Jackson Memorial Hospital, Miami, Fla.

The University of Louisville School of Medicine last year received $7,791 from the American Medical Education Foundation. The money came from a help-the-schools-that-helped-you program by the nation's doctors. The A.M.E.F. distributed $1,172,599 collected through the program to 85 medical schools. All funds contributed by doctors are distributed. The AMA pays administrative costs.

Contributions from industry to the National Fund for Medical Education in 1960 reached a new high of $2,418,221, S. Sloan Colt, President of the National Fund announced. This sum represents an increase of 8.8 per cent over money contributed in 1959. Aided by a matching grant of $919,000 from the Ford Foundation, the Fund was enabled to make awards to the nation's 85 medical schools of $4,138,460. This is an increase of $100,000 over grants made in 1959. (The University of Louisville School of Medicine in 1959 received $37,200 from the Fund. In 1960 the School received $37,380.)



IN COLDS AND SINUSITIS— THE RIGHT AMOUNT OF "INNER SPACE" RIGHT AWAY

Neo-Synephrine hydrochloride relieves the boggy feeling of colds immediately and safely, without causing systemic toxicity or chemical harm to nasal membranes. Turbinates shrink, sinus ostia open, ventilation and drainage resume, and mouth-breathing is no longer necessary.

Gentle Neo-Synephrine shrinks nasal membranes for from two to three hours without stinging or harming delicate respiratory tissues. Post-therapeutic turgescence is minimal. Neo-Synephrine does not lose its effectiveness with repeated applications nor does it cause central nervous stimulation, jitters, insomnia or tachycardia.

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NASAL SOLUTIONS AND SPRAYS

For wide latitude of effective and safe treatment, Neo-Synephrine hydrochloride is available in nasal sprays for adults and children; in solutions from ⅛% to 1%; and in aromatic solution and water soluble jelly.

News Items

Governor Bert Combs dedicated the new **J. W. Crook Memorial Craft House** on August 2 at the J. M. Feltner Memorial 4-H Club camp at London. The craft house, to house machinery for crafts work, is a memorial to the late **J. W. Crook, M.D.**, a London and Eastern Kentucky physician for many years. **Mrs. Crook** donated the funds last year for the new building.

Holmes G. Sargent, M.D., Barlow, State Health Director for that area, has gone to Johns Hopkins University for a year's specialist training in Public Health Administration. He will return to the Health Department next year.

L. Jack Scott, M.D., has begun general practice in association with **William Russell, M.D.**, Bowling Green. A native of Williamstown, W. Va., Doctor Scott received his medical degree from the University of Louisville in 1960 and interned in Georgia.

Richard C. McPherson, M.D., a 1954 graduate of the Ohio State University Medical School is a member of the department of surgery of the Louisville General Hospital and the U. of L. School of Medicine. Doctor McPherson, a native of Lisbon, Ohio, interned at the City Hospital of Akron and took residency training at Ohio State University. He was a captain with the U. S. Air Force and served with it as a general surgeon in Turkey from 1957 to 1959.

Lon C. Hall, M.D., has returned to his former office at the Paintsville Hospital after 18 months training in pediatrics at Children's Medical Center, Boston. Doctor Hall is a 1930 graduate of the U. of L. School of Medicine.

A 1956 graduate of the University of Louisville School of Medicine, **Ronald G. Fragge, M.D.**, has begun a practice in Covington limited to Chest disease and allergy. Doctor Fragge interned at Cincinnati Jewish Hospital and took residency training in the Chest Service of Bellevue Medical Center, New York, and the Institute of Allergy at Roosevelt Hospital, also in New York.

James L. Beck, M.D., a native of Jamestown, Ky., has begun general practice in Burkesville, in association with **Norman K. Kirby, M.D.**, Doctor Beck, a 1960 graduate of the University of Louisville School of Medicine, interned at the University of Oklahoma Medical Center.

Joe S. Wheeler, M.D., who received his medical degree from Tulane University in 1957, has begun practice in Ashland. He interned and took residency training at Southern Baptist Hospital. Doctor Wheeler, associated with **Edward W. Connelly, M.D.**, limits his practice to obstetrics and gynecology.

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In Addition To Suitable Medical and Nursing Care for Chronic, Convalescent and Geriatric Patients

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NEW CASTLE, KY.

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Licensed and Approved by State of Ky.

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Diversional activities, physio-therapy treatments, rehabilitation program and emergency facilities available.

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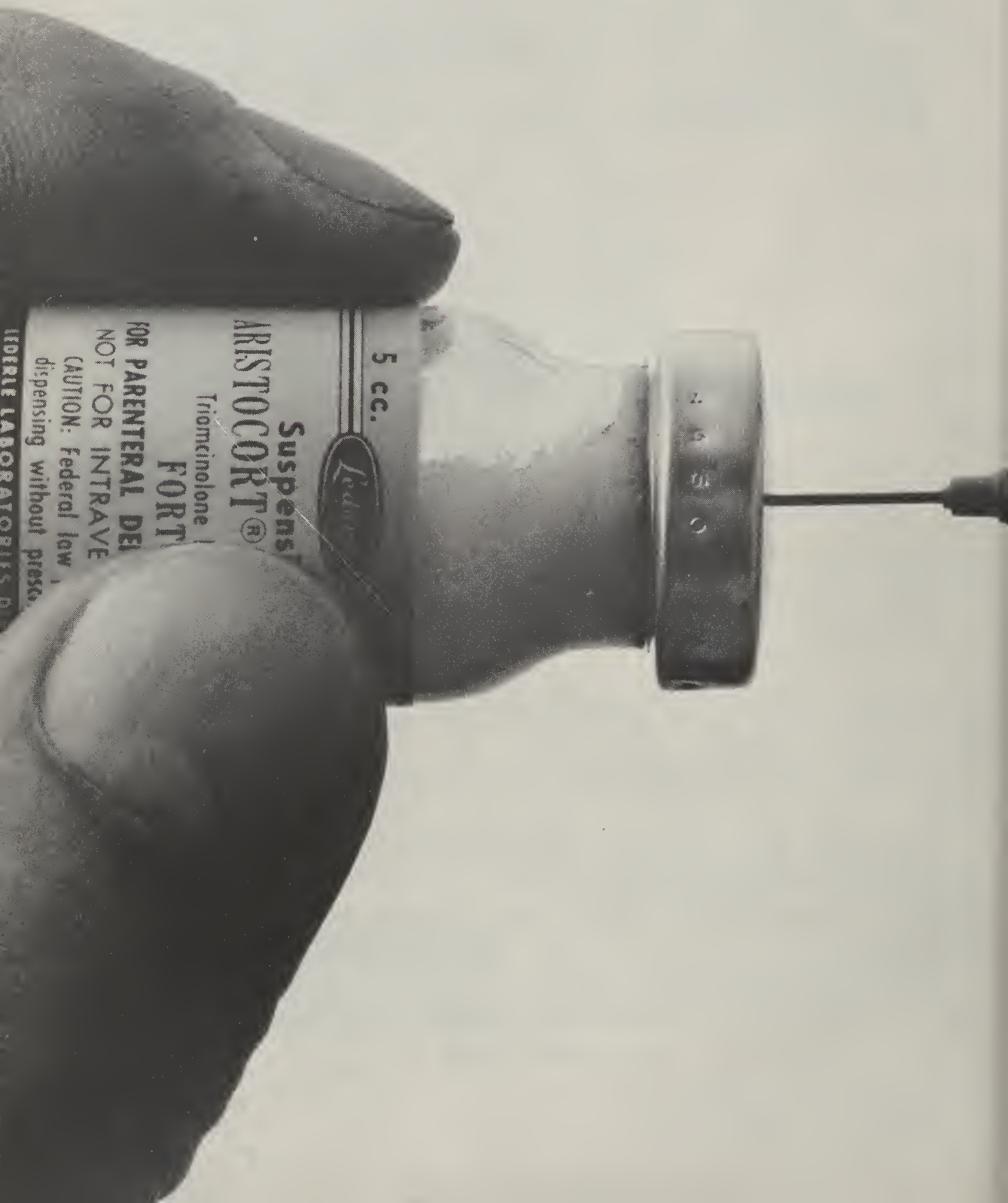
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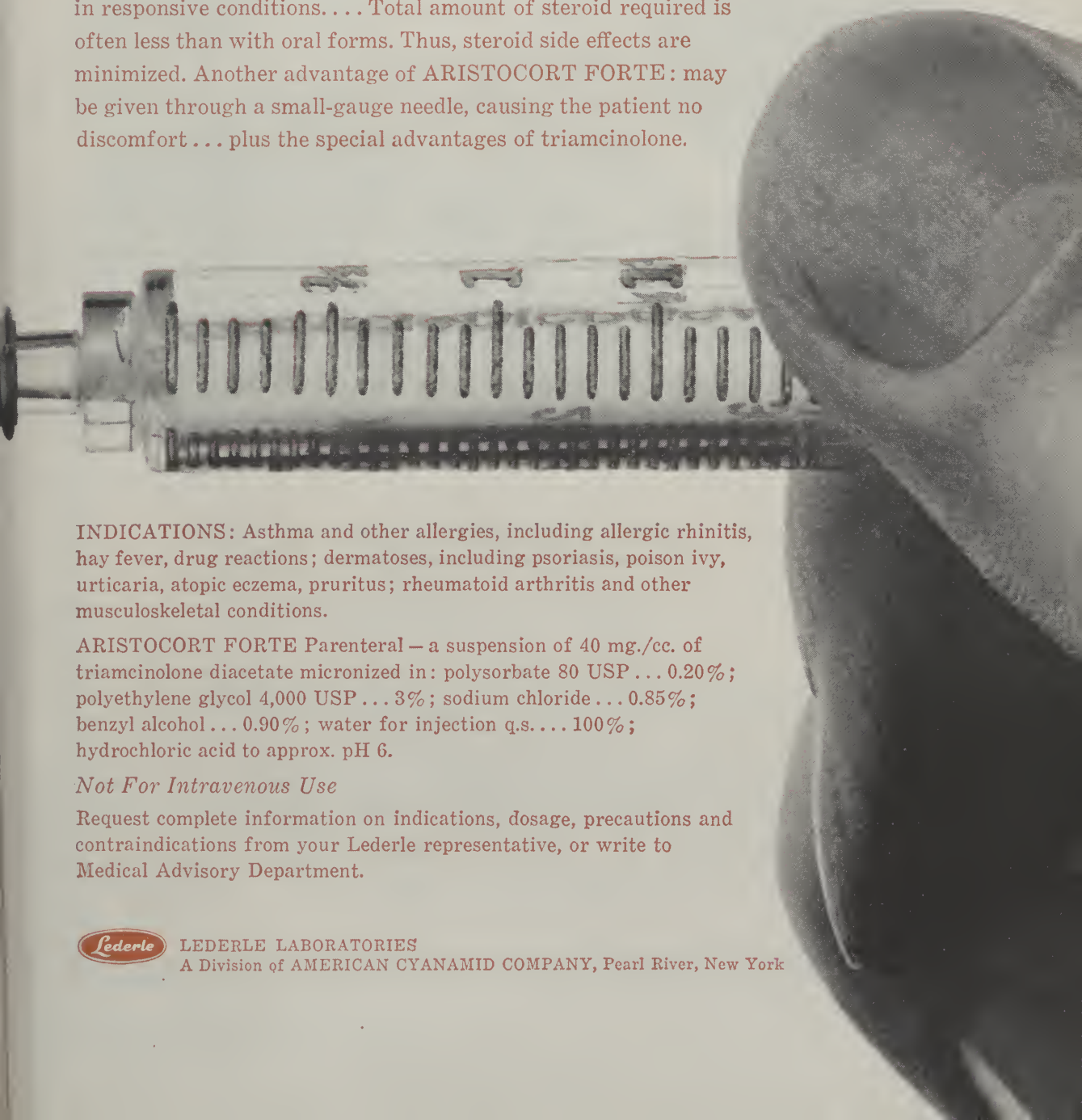
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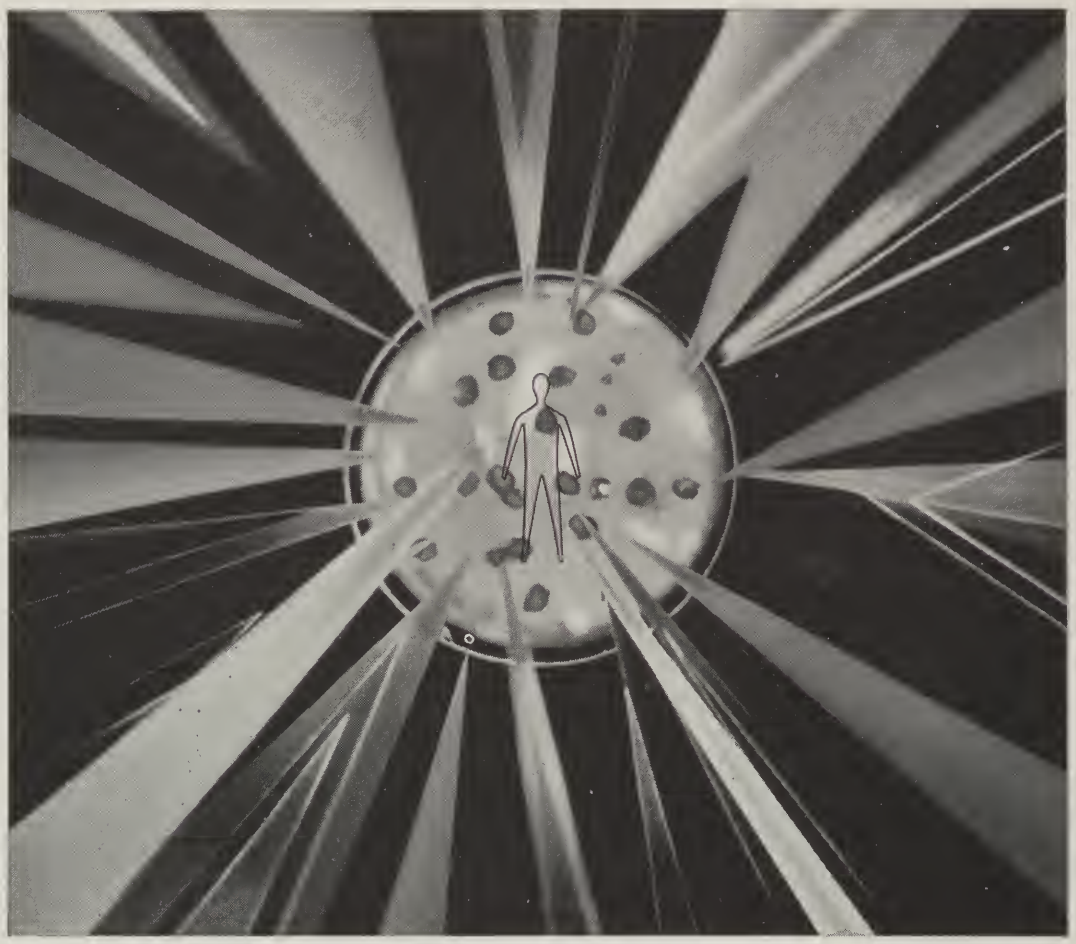
INDICATIONS: Asthma and other allergies, including allergic rhinitis, hay fever, drug reactions; dermatoses, including psoriasis, poison ivy, urticaria, atopic eczema, pruritus; rheumatoid arthritis and other musculoskeletal conditions.

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For full information, see your Squibb Product Reference or Product Brief.

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News Items

Donald E. Edger, M.D., Lexington, has opened an office and will limit his practice to obstetrics and gynecology. A 1955 graduate of the University of Cincinnati Medical School, Doctor Edger interned at Cincinnati General Hospital and took residency training in the Baylor University of Medicine affiliated residency program. He served as senior assistant surgeon with the USPHS from 1956 to 1958.

A native of McRoberts, Ky., **Lloyd H. Pendergrass, M.D.**, has begun general practice in association with **W. R. Kingsolver, M.D.**, Carlisle. He received his medical degree from the University of Louisville in 1960 and interned at Orange Memorial Hospital, Orlando, Fla.

William H. Wright, M.D., has been appointed health officer for Lewis, Bracken, and Robertson counties. A native of New Albany, Ind., he is a 1958 graduate of the University of Louisville School of Medicine and interned at Los Angeles County General Hospital. Doctor Wright served as a general medical officer in the U. S. Air Force with the rank of captain.

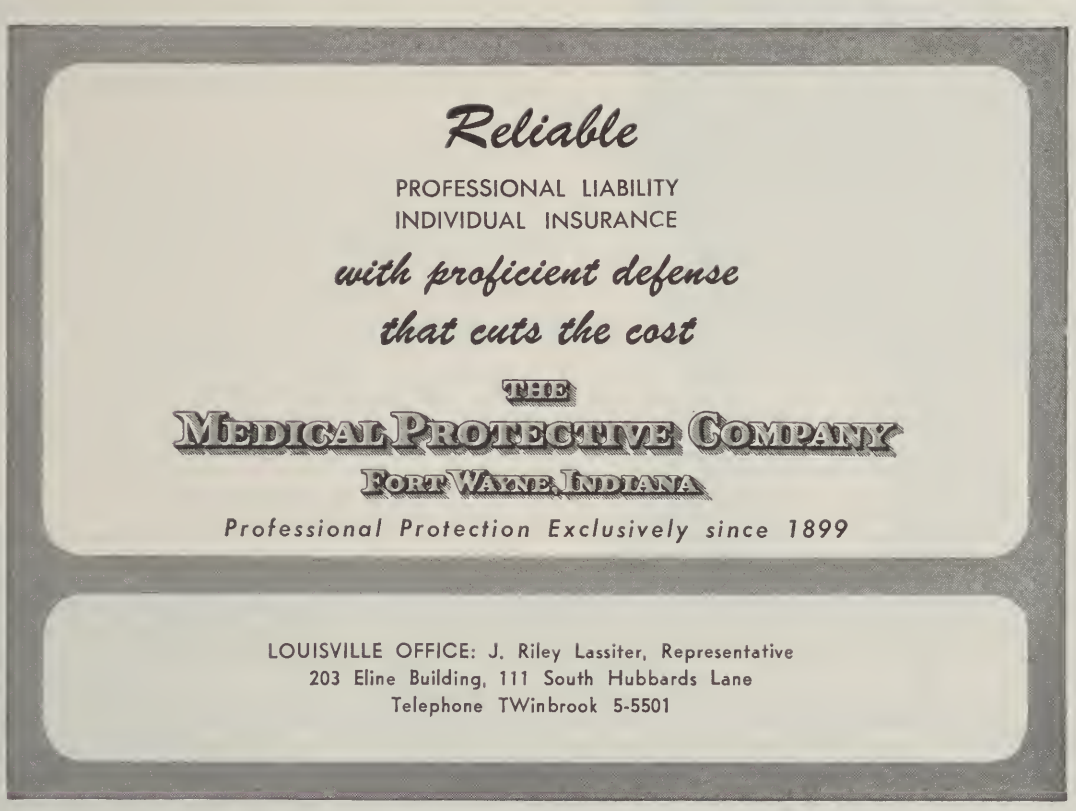
A 1960 graduate of the University of Louisville School of Medicine, **John M. Reed, M.D.**, will do general practice in Mayfield in association with **James E. Albritton, M.D.; Richard L. Colley, M.D.; and Jacob M. Mayer, M.D.** Doctor Reed interned at St. Joseph Infirmary, Louisville.

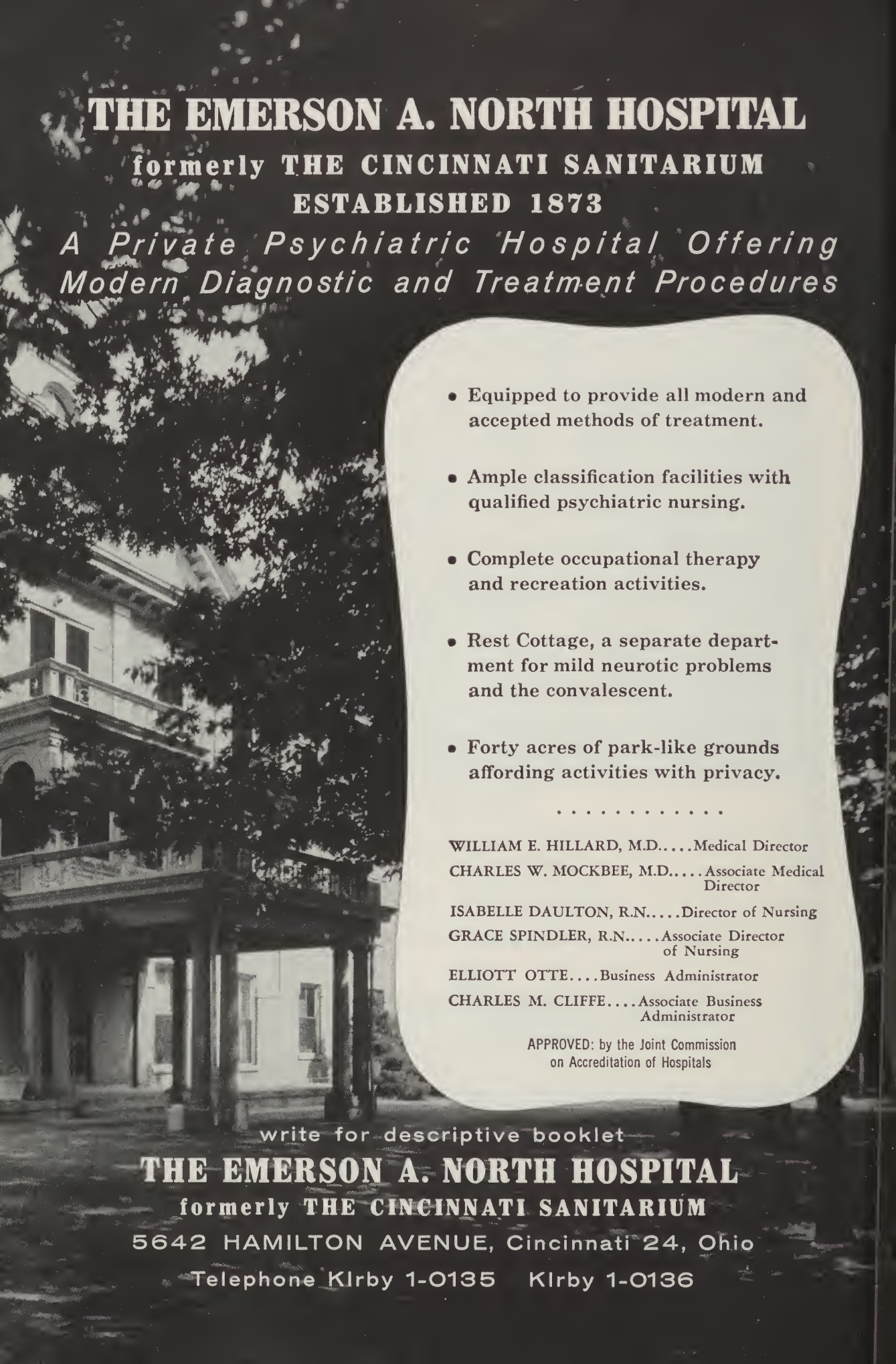
Donald C. Barton, M.D., has begun practice in Corbin in association with **William M. Brown, M.D.** A 1960 graduate of the University of Louisville School of Medicine, Doctor Barton interned at Louisville General Hospital.

A 1960 graduate of the University of Tennessee Medical School, **James Ray Ammons, M.D.**, has begun practice in association with the **Houston-McDevitt Clinic**, Murray. Doctor Ammons interned at Methodist Hospital, Memphis, Tenn., and has served in the U. S. Marine Corps.

Robert L. Hast, M.D., who received his medical degree from Indiana University in 1954, has begun practice in Owensboro in association with **Frank L. Yarbrough, M.D.; Harold J. Schupbach, M.D., and John D. Lovett, M.D.** Doctor Hast, a native of Evansville, Indiana, interned at St. Margaret Hospital, Hammond, Indiana, and took residency training at Henry Ford Hospital, Detroit, Michigan. He served for two years with the U. S. Army with the rank of captain. Doctor Hast will limit his Owensboro practice to internal medicine.

A Martin native, **James D. Adams, M.D.**, has begun general practice in Prestonsburg. Doctor Adams received his medical degree from the University of Louisville in 1960 and interned at Louisville General Hospital.





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News Items

Donald L. Boucher, M.D., who received his medical degree from the University of Minnesota in 1953, has opened a practice in Paducah limited to otolaryngology. Doctor Boucher, a native of Minneapolis, Minn., interned in St. Paul, Minn., and took residency training at the University of Minnesota. He served six and one-half years in the U.S. Navy and has practiced previously at Lexington and Hazard.

Two new doctors have opened an office for general practice in Berry, Ky. **Donald R. Stephens, M.D.**, a Williamsburg native, and **Joe M. Withers, M.D.**, a Cynthiana native, are 1960 graduates of the University of Louisville School of Medicine. Both interned at St. Elizabeth Hospital, Dayton, Ohio.

James L. Ferrell, M.D., has begun a general practice in the office formerly occupied by the late J. C. Hart, M.D., Paris. Doctor Ferrell graduated from the Medical College of Virginia in 1958 and interned at Brighton Marine Hospital, Boston. He served as senior assistant surgeon with the U. S. Public Health Service for three years.

C. Richard Gill, M.D., a native of Washington, D. C., and a 1955 graduate of George Washington University Medical School, has begun a practice of internal medicine in association with the Lexington Clinic. Doctor Gill interned at Duke Hospital, Durham, N. C., and took residency training at Mayo Clinic, Rochester, Minn. He served for two years as a captain in the U. S. Army Medical Corps and had practiced in Minnesota before coming to Kentucky. He has a special interest in rheumatology.

Bill G. Jackson, M.D., a native of Murray, has begun general practice in association with **Ralph Cash, M.D.**, Princeton. Doctor Jackson graduated from the University of Louisville School of Medicine in 1959. He interned at St. Louis County Hospital and took a general surgery residency training there.

A 1960 graduate of the University of Louisville School of Medicine, **Charles A. Webb, M.D.**, Ashland, has begun general practice in association with **C. Wayne Franz, M.D.**, and **Eugene Slusher, M.D.** Doctor Webb served his internship at St. Elizabeth Hospital, Dayton, Ohio.

Jack D. Lewis, M.D., has begun general practice in Mt. Vernon in association with **George H. Griffith, M.D.** Doctor Lewis is a 1960 graduate of the University of Louisville School of Medicine. He interned at Wesley Hospital, Wichita, Kansas.

Frank H. Catron, M.D., will do general practice in Corbin in association with **Keith P. Smith, M.D.** Doctor Catron received his medical degree from the University of Louisville in 1960 and interned at St. Joseph Infirmary and Norton Memorial Infirmary, Louisville.

A Cincinnati native, **Joyce Elaine Howell, M.D.**, received her medical degree from Woman's Medical College of Pennsylvania and has begun general practice in association with **C. Milton Young, M.D.**, Louisville. Doctor Howell interned at Miami Valley Hospital and took residency training in pediatrics and internal medicine at Hubbard Hospital, Nashville, Tenn.

Lyle C. Franz, M.D., has begun the practice of pediatrics in Maysville. Doctor Franz, a Lebanon, Ohio, native, practiced previously in Ripley, Ohio. He is a 1938 graduate of the University of Louisville School of Medicine and interned at Good Samaritan Hospital, Cincinnati. He served as a captain in the U. S. Air Force from 1942 to 1945.

Luther F. Young, M.D., has begun practice in association with Middlesboro Memorial Hospital. A native of Waldens Ridge, Tenn., Doctor Young received his medical degree from the University of Tennessee in 1958 and interned at Erlanger Hospital, Chattanooga, Tenn. He served with the U. S. Navy for four years and has pacticed previously with Man Memorial Hospital, Man, W. Va.

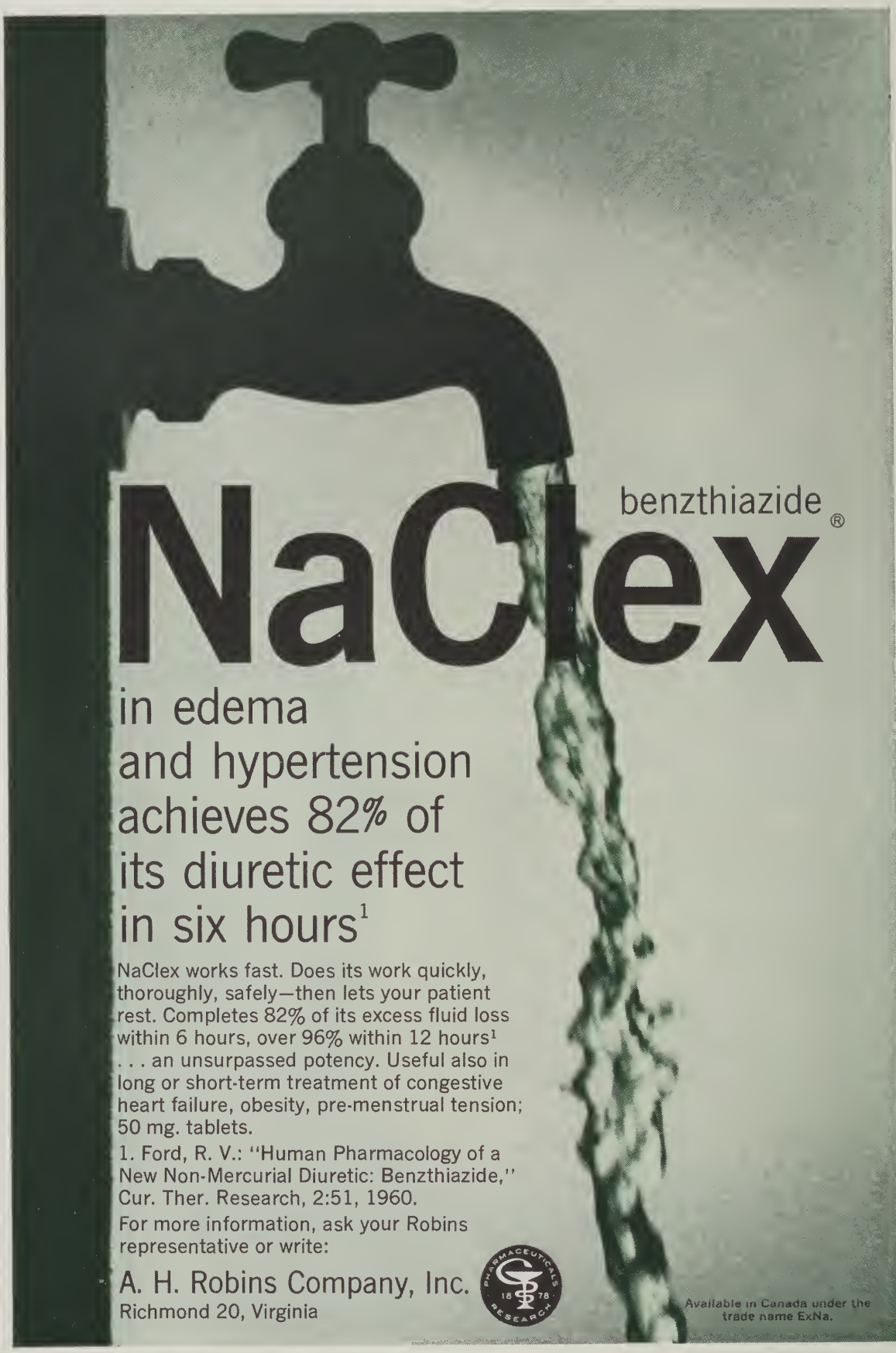
A Murfreesboro, Tenn., native, **Andrew P. Nelson, M.D.**, has begun general practice in Fulton, Ky., in association with **John W. Ragsdale, Jr., M.D.** Doctor Nelson received his medical degree from the University of Tennessee in 1960 and interned at John Gaston Hospital. He served for two years in the medical service corps of the U. S. Army.

Richard Bernard Budde, M.D., is associated with Doctors Mayfield, Lotspeich, and Hunter in the practice of neuro-surgery in Cincinnati. In addition, Doctor Budde is practicing on a part-time basis in Covington, his home town. He received his medical degree from St. Louis University in 1955; interned and took residency training in general and neuro-surgery at Cincinnati's Good Samaritan Hospital and General Hospital.

A 1955 graduate of the University of Louisville School of Medicine, **Oscar W. Thompson, Jr., M.D.**, has opened an office in Pikeville for the practice of internal medicine. He interned at Lloyd Nolan Hospital and took his residency training at the University of Michigan. Doctor Thompson served in the U. S. Air Force with the rank of captain.

A 1960 graduate of the University of Tennessee Medical School, **Clifford F. Kerby, M.D.**, is now associated with **Earl T. Hays, Jr., M.D.**, Berea, in a general practice. Doctor Kerby interned at Baptist Memorial Hospital, Memphis, Tenn., and served for three and one-half years with the U. S. Air Force.

Graydon A. Long, M.D., Lexington, received a fellowship certificate from the American College of Chest Physicians at its 27th Annual Meeting, June 22-26 in New York City. Fellowship certificates were conferred on 204 physicians at the meeting.


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NaClex
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achieves 82% of
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NaClex works fast. Does its work quickly, thoroughly, safely—then lets your patient rest. Completes 82% of its excess fluid loss within 6 hours, over 96% within 12 hours[1] . . . an unsurpassed potency. Useful also in long or short-term treatment of congestive heart failure, obesity, pre-menstrual tension; 50 mg. tablets.
1. Ford, R. V.: "Human Pharmacology of a New Non-Mercurial Diuretic: Benzthiazide," Cur. Ther. Research, 2:51, 1960.
For more information, ask your Robins representative or write:
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PHARMACEUTICALS 1878 RESEARCH
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Answers to Questions About Your BLUE SHIELD

Q.—Will Blue Shield give information regarding a member's diagnosis to one of his family?

A.—No. The contract entered into by Blue Shield and the member reads: "I consent that the physician having treated or who shall treat the members covered herein or the hospital in which treatment was rendered may furnish the diagnosis and history of such treatment to the corporation(s) and that such information will be treated as confidential.

Q.—Do all Blue Shield plans make payment direct to the doctor?

A.—No, some are required by state law or local Blue Shield regulations to make payment direct to the patient. Kentucky Physicians Mutual, however, feels that the check should go directly to the doctor who renders service.

Q.—Can one member in a group take Preferred Blue Shield and the rest of the members in the group carry Standard Blue Shield?

A.—Yes, if the person and/or his family meet underwriting regulations.

Q.—What is Health Service, Inc.?

A.—It is a stock company owned by Blue Cross Association. Health Service, Inc., contracts with national firms to provide prepayment of health services on the basis of uniform rates and benefits, with standard enrollment and billing procedures.

Q.—What is Medical Idemnity of America?

A.—Medical Indemnity of America, Inc., the national underwriting agency for Blue Shield Plans, serves as a contracting agency with national firms for the provision of Blue Shield benefits.

Q.—How do I submit a claim when the patient has his surgical-medical protection with Health Service or Medical Indemnity of America?

A.—These claim forms should be available in the group where the member is enrolled. If they are not, the member or doctor may contact Kentucky Physicians Mutual, Inc., 3101 Bardstown Road, Louisville 5, Kentucky for claim forms. Health Service or Medical Indemnity claims should be mailed to 200 North Michigan Avenue, Chicago 1, Illinois.

Q.—How do I submit a claim on a patient who is a Blue Shield member of a plan in another state?

A.—Use a Kentucky Physicians claim form and mail to the address shown on the identification card.

Q.—What are the duties of the Medical Adviser to Blue Shield?

A.—To review cases requiring professional knowledge and to advise with members of the staff on medical matters.

Q.—Why does Blue Shield refuse to approve care of a member prior to rendering service?

A.—Since a Blue Shield subscriber may cancel his membership at any time, or sometimes change his membership, claims cannot be approved prior to the actual rendering of service. All Blue Shield claims are paid on the basis of a member's status at the time services are rendered.



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Each tablet provides: Dehydrocholic Acid Compound, P-M Co. 265 mg. (Dehydrocholic Acid, 250 mg.); Homatropine methylbromide 1.2 mg.; Phenobarbital 8.0 mg. Supplied in bottles of 100 tablets.

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Weight problem? Start the reducing program right, keep it going right with Esidrix® Esidrix-K®

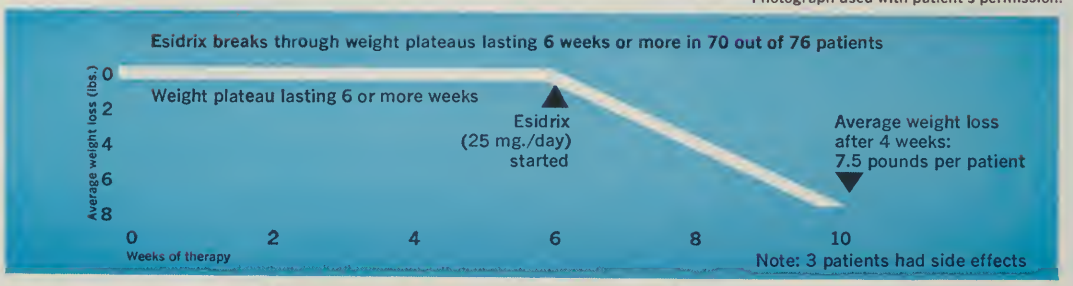
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1. As an adjuvant in initiating treatment: Esidrix induces greater weight losses in the first few days than a conventional regimen.[1] This weight loss may be significant in itself (depending on the degree of fluid retention). But more than that, the quick loss of even a few pounds builds confidence in the weight-reducing program, inspires determination to follow it faithfully.

2. As an adjuvant in maintenance treatment: Esidrix eliminates retained water—with consequent weight losses—to break through the weight plateaus so often encountered in antiobesity programs. (See schematic graph below.) The new weight loss cheers the patient and helps overcome his tendency to eat too much.



Photograph used with patient's permission.



(Adapted from Einhorn and Kalb[2])

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For complete information about Esidrix and Esidrix-K (including dosage, side effects, and cautions), see Physicians' Desk Reference, or write CIBA, Summit, N. J.

References: 1. Ray, R. E.: To be published. 2. Einhorn, H. P., and Kalb, S. W.: Clin. Med. 7:1995 (Oct.) 1960.

Supplied: ESIDRIX Tablets, 25 mg. (pink, scored) and 50 mg. (yellow, scored). ESIDRIX-K Tablets 25/500 (white, coated), each containing 25 mg. Esidrix and 500 mg. potassium chloride. **NEW STRENGTH ESIDRIX-K NOW AVAILABLE:** ESIDRIX-K Tablets 50/1000 (white, coated), each containing 50 mg. Esidrix and 1000 mg. potassium chloride.

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Outstandingly Safe and Effective



for the tense and
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1 simple dosage schedule relieves anxiety dependably – without the unknown dangers of "new and different" drugs

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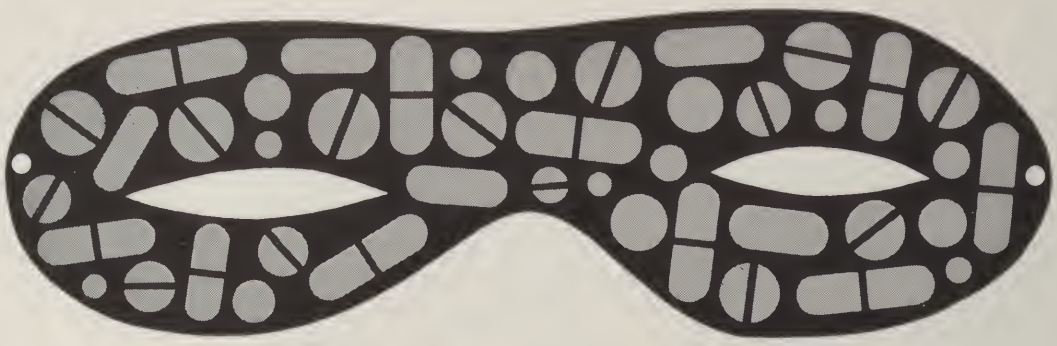
Usual dosage: One ar two 400 mg. tablets t.i.d.
Supplied: 400 mg. scared tablets, 200 mg. sugar-coated tablets; battles af 50. Alsa as MEPROTABS*—400 mg. *unmarked*, caated tablets; and in *sustained-release* capsules as MEPROSPAN®-400 and MEPROSPAN®-200 (containing respectively 400 mg. and 200 mg. meprabamate).
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drugs anonymous

One of the several hastily conceived and potentially dangerous suggestions for reducing drug costs is generic-name prescribing. The proponents of generic-name prescribing claim that it will lower drug costs significantly and—through supervision by the Federal Government—provide quality equivalent to that of trademarked drugs. We maintain that these claims are false. Here are some authoritative answers to the principal questions posed by generic-name prescribing.

How much money would be saved if all prescriptions were written for generic-name drugs?

"The [Rhode Island] Division of Public Assistance examined 10,000 drug prescriptions for welfare recipients for the purpose of determining the actual savings . . . of generic versus trade-name drugs. The drugs had cost $28,000. Substituting generic drugs whenever possible would have provided a saving of less than 5 per cent. Syracuse has made a similar study of drug costs with comparable results."

Rhode Island Medical Journal,
January, 1961

Are the savings worth the risk of sacrificing quality?

". . . it is unsafe [to prescribe generically] because there is not sufficient policing of our standards. . . ."

Lloyd C. Miller, Ph. D.
Director of Revision of the U.S.P.

"The naive belief that, if a product was not good, the FDA would prohibit its sale is just not realistic. . . . it is completely impossible for the FDA to check every batch of every product of every manufacturer. . . . Hence the integrity and reputation of the manufacturer assume unusual significance where drugs and health products are concerned."

Albert H. Holland, M.D.
formerly Medical Director of the
Food and Drug Administration

Smith Kline & French Laboratories, Philadelphia

Increasingly...
the
trend is to
Terramycin®
OXYTETRACYCLINE WITH GLUCOSAMINE

confirmed dependability in otitis media is just one reason why



*New evidence** demonstrates the effectiveness of Terramycin in *otitis media* . . . another reason for the trend to Terramycin.

In a series of 41 cases of otitis media, Terramycin not only "was often successful where other antibiotics had failed," but also showed that "it is extremely well tolerated"; oral dosage for infants was 250 to 375 mg. daily, for children, 500 mg. to 1 Gm. In many instances, oral therapy was preceded by intramuscular injection of Terramycin.

The authors concluded that "there is good reason to consider it [Terramycin] one of the most effective agents for treatment of infection of the upper respiratory tract."

These findings confirm the continuing vitality and broad-spectrum dependability of Terramycin, as reported through more than a decade of extensive clinical use.



In brief

The dependability of Terramycin in daily practice is based on its broad range of antimicrobial effectiveness, excellent toleration, and low order of toxicity. As with other broad-spectrum antibiotics, overgrowth of nonsusceptible organisms may develop. If this occurs, discontinue the medication and institute appropriate specific therapy as indicated by susceptibility testing. Glossitis and allergic reactions are rare. Aluminum hydroxide gel may decrease antibiotic absorption and is contraindicated.

More detailed professional information available on request.

another reason why the trend is to Terramycin—*versatility of dosage form:*

TERRAMYCIN Capsules—
250 mg. and 125 mg. per capsule—for convenient initial or maintenance therapy in adults and older children

TERRAMYCIN Intramuscular Solution—
50 mg./cc. in 10 cc. vials; 100 mg. and 250 mg. in 2 cc. ampules—preconstituted, ready to use where intramuscular therapy is indicated

Terramycin®

OXYTETRACYCLINE WITH GLUCOSAMINE

SYRUP PEDIATRIC DROPS

125 mg. per tsp. and 5 mg. per drop (100 mg./cc.), respectively

deliciously fruit-flavored aqueous dosage forms—conveniently preconstituted

Science for the world's well-being® Pfizer

PFIZER LABORATORIES Division, Chas. Pfizer & Co., Inc.
New York 17, N. Y.

*Jacques, A. A., and Fuchs, V. H.: J. Louisiana M. Soc. 113:200, May, 1961.

Pfizer *Science for the world's well-being®*

Dear Doctor:

Reports from our representatives indicate that many physicians would appreciate simplification for prescription-writing purposes of the names of Terramycin products in both the "plain" and the "Cosa" dosage forms.

The "Cosa" forms originated, you may recall, on the basis of clinical evidence of enhanced antibiotic absorption when glucosamine is employed in oral administration. To permit each physician individually to study this evidence and choose which form he would prefer to prescribe, we offered Terramycin in both forms—that is, in the regular Terramycin forms without glucosamine, and in the "Cosa" forms with glucosamine.

This distinction appears to be no longer necessary since glucosamine, a highly acceptable excipient for oral antibiotics, now is being incorporated uniformly in all such forms, thereby simplifying nomenclature and your prescription writing.

Accordingly, and effective immediately, forms incorporating glucosamine will be offered simply as Terramycin without the "Cosa" prefix.

To make clear just which forms are affected, please refer to the brief tabulation (below) of Terramycin dosage forms both *before* and *after* this change. We are also requesting our representative to call on you at an early date to answer any questions that may arise.

We feel certain that this action, prompted by your comments and those of many other physicians, will simplify your writing of prescriptions for Terramycin products.

We welcome your comments on this action and on any other phase of our operations, since it is our objective to render every service as efficiently as possible to our friends in the medical profession.

Sincerely,
PFIZER LABORATORIES

The following table indicates the former name and the current name of Terramycin systemic preparations:

FORMERLY NAMED	NOW NAMED
Cosa-Terramycin® Capsules	**Terramycin**® Capsules*
Cosa-Terrabon® Oral Suspension	**Terramycin** Syrup
Cosa-Terrabon Pediatric Drops	**Terramycin** Pediatric Drops

and simpler names for these Terramycin-containing formulations:

Cosa-Terrastatin® Capsules	**Terrastatin**® Capsules
Cosa-Terrastatin for Oral Suspension	**Terrastatin** for Oral Suspension
Cosa-Terracydin® Capsules	**Terracydin**® Capsules

. . . and these names remain unchanged:
Terramycin Intramuscular Solution
Terramycin Intravenous

**Terramycin Capsules* without glucosamine *are no longer available.*

The clinical versatility of Terramycin is enhanced by its specialized dosage forms adapted to individual needs—*another reason for the trend to Terramycin.*



IN THE BOOKS



MANAGEMENT OF HYPERTENSIVE DISEASES: by Joseph C. Edwards, A.B., M.D., F.A.C.P., F.A.C.C.; published by C. V. Mosby Co., St. Louis, 1960; 439 pages; Price $15.00.

The author states in his preface that his book 'is intended to serve as a guide to the practical management of the patient with hypertensive disease." He accomplishes far more. Etiology, classification, diagnosis, management, and pharmacology are all covered with a thoroughness which is striking in view of the comparative brevity of the book. Rigid criteria and schedules are avoided in the discussion of therapy, but principles are fully presented. The result is not a book for leisure reading and at times careful concentration is necessary to follow the line of thought. Nevertheless, the effort is worth while and in the sections on management there is ample clarification with illustrative cases.

The bibliography of 1622 references should be of great value to the student who wishes to pursue his investigation further. This is accumulated in the back of the book with cross references from the text.

Indexing is adequate, rendering the book useful as a reference text. The author states: "It is written for the busy physician in practice who wants the latest information on the treatment of hypertension and guidance in selecting proper medication for a particular patient." It accomplishes this purpose and it should also be of value to the medical student and to the graduate in residency training.

Carl H. Fortune, M.D.

HANDBOOK OF PEDIATRICS: Henry K. Silver, M.D., C. Henry Kempe, M.D., and Henry B. Bruyn, M.D.; published by Lange Medical Publications, Los Altos, California; 574 pages; price $3.50.

The purpose of this paper-bound book is to supplement in a brief form the larger textbooks. The authors have tried to give the medical student and intern a quick reference to all of the practical diseases and therapy found in pediatrics.

The material is well placed and is in concise, readable form. Most of the subject matter is given as an outline. Since this is a handbook, the pictures are few and the tables are many. To preserve space there is very little reference material given.

When a person tries to analyze the usability of a handbook, he looks for a few essential features. These consist of a good index and a print that is easily readable. This handbook has a good index, but the print is very poor. In the copy that was sent to this reviewer at least 100 pages were printed and inserted upside down.

This fourth edition has an excellent chapter on the psychological aspects of adolescence. Also, there are many tables relating to physical growth during adolescence. The section on surgical emergencies should prove worthwhile to the general pediatrician. The section on poisons lists several hundred poisons by brand name and has a quick reference for antidotes.

In summary, we can say that this handbook should prove useful where brevity and information in table form are necessary.

Elliott Podoll, M.D.

CLINICAL DIRTURBANCES OF RENAL FUNCTION: by Abraham K. White, M.D., F.A.C.P.; published by W. B. Saunders Co., Philadelphia and London; 468 pages; price $10.50.

In few clinical situations is the bedside application of physiologic information more urgent than in the diagnosis and management of the patient with kidney disease. The great extension of our knowledge of the normal and diseased kidney in the last decade has made clinicophysiologic correlation more mandatory and also more difficult.

Doctor White's book is an attempt to correlate some of this newer information in a manner useful to the practitioner in his daily contacts with renal disease. The common and uncommon renal syndromes are reviewed in the light of pertinent data obtained in such varied areas as renal biopsy, electron microscopy, ion exchange mechanisms, the concentration and acidification of the urine, pyelonephritis and the genetic renal tubular metabolic disorders. In each instance, the clinical and physiologic information is correlated and related to management.

The objectives of the book have been moderately well achieved. The presentation is clear, coverage is adequate, and the organization of material is well conceived. The information is usually up to date, though admittedly simplified. It is supported by a limited but well selected bibliography. Illustrations and diagrams are well integrated into the text. Occasionally they suffer from excessive and indiscriminate use of detail.

The first part of the book is concise and pertinent. There is unnecessary repetition in the latter part however. The book could be improved by extensive condensation in the sections which deal with the extra-renal factors which modify renal function. The author often digresses into extraneous matters treated better in other works; this is especially true of the chapters on heart failure, liver disease, endocrine function and the genetically induced tubular disorders.

Occasionally the tone is too chatty. Sentences could be defatted of unnecessary phrases. There is room for disagreement with a number of the author's recommendations especially regarding bed rest, the value of pyelography in pyelonephritis, and his classification

(Continued on Page 927)

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CASE 263

my husband and I had suffered backaches every morning. My back got so bad I was in traction for a week. The doctor recommended a Posturepedic mattress. We bought one and now enjoy a good night's sleep, get up full of pep, and can do a day's work without backaches.

(Excerpt of letter from
Mrs. M. G., San Francisco, California. Name available on request.)

You know that chronic lower back trouble is not a simple matter. The Posturepedic mattress, then, cannot be a "cure." But patients who have tried Posturepedic and doctors who use it, too, know it *can help*. They find the firm, level support Posturepedic gives to spine and muscular system in back and limbs promotes normal, healthful sleep among *all* persons.

The Sealy Posturepedic, as you undoubtedly know, is designed in cooperation with leading orthopedic surgeons. We believe your investigation and *personal use* will firmly convince you of its distinctive benefits and, we would hope, merit your valued recommendation. Why not prove it to yourself by taking advantage of this liberal professional discount plan now?



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We invite you to take advantage of a professional discount.

This is a saving of $39 per set over the regular retail price for innerspring mattress and matching foundation. Limit: one full or two twin size sets. MAIL TO: Sealy Div., Logan Co., 200 Cabel St., Louisville 6, Ky.

☐ Enclosed is my check. Please send the Sealy Posturepedic set(s) indicated below.

☐ 1 Full Size
☐ 1 Twin Size ☐ 2 Twin Size

☐ Please send me additional information about professional discounts on Sealy Posturepedic mattresses.

	Retail	Professional
Posturepedic Mattress each $79.50 (add state tax)		$ 60.00
Posturepedic Foundation each $79.50 (add state tax)		$ 60.00
Posturepedic in Foam Rubber $159.00 per *set* (add state tax)		$120.00

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*Residence*_____

*City*_____ *Zone*_____ *State*_____

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Philips Roxane comes to you as a new name in American pharmaceutical manufacture. But our roots go deep. We have well-established resources in this country. In Holland and elsewhere in Europe, we have access to research from which substantial contributions have been made in the areas of human, animal and plant health.

A wide range of new pharmaceuticals is now being developed which will have significant usefulness to you in your practice.

For example, extensive studies are now being carried out in organic synthesis, vaccines, and radioactive isotopes. Some of these pharmaceuticals and biologicals are presently undergoing clinical trials in this country.

One research project nearing completion is a measles vaccine, now undergoing extensive U. S. clinical trial. Another preparation, soon to be available, is a progestational agent which gives promise of offering distinct advantages over those presently available. A true progestin, it will have wide application in female disturbances without androgenic, estrogenic, or corticosteroid side effects.

Philips Roxane has acquired affiliates throughout the United States, where research and development in human, animal and plant medicines are being greatly extended through their production facilities and sales organizations.

The name Philips Roxane will become as familiar to you as the names of many other fine pharmaceutical houses in this country, whose products and people serve you faithfully.



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Dimetapp® Extentabs®

et your sinusitis, allergy and U.R.I. patients breathe easier!

DIMETAPP Extentabs contain Dimetane®(parabromdylamine [brompheniramine] maleate) 12 mg., henylephrine HCl 15 mg., and phenylpropanolamine HCl 15 mg., a proved antihistamine and two utstanding decongestants. The dependable Extentab form provides sustained relief from the tuffiness, drip and congestion of sinusitis, colds and U. R. I. for 10-12 hours with a single dose.

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From the files of the
COMMITTEE FOR THE
STUDY OF MATERNAL MORTALITY



CASE No. 76—1959—This patient was a 28-year-old married, white gravida 2, para 1. Her first delivery, in 1956, was by classical cesarean section; the indication of section was not known.

In the 32nd week of gestation, the patient was admitted in critical condition with the diagnosis of ruptured uterus. She was promptly transfused with universal donor blood through a cut-down. Her condition impoved, and an unweighed male stillborn fetus was delivered by laparotomy. The operative findings and surgical procedure were not further described. The patient seemed to be in good condition several minutes following the completion of the undescribed operation, then suddenly showed signs of shock and respiratory failure. No mention was made of the amount of blood administered, nor of what anesthetic was used. The attending physician thought she might have suffered a cerebral embolus, since the left pupil was noted to be dilated. The heart continued to beat for several minutes, but respirations were never restored. She was pronounced dead at 5:48 a.m. on November 21, 1959.

No autopsy was performed. The cause of death was listed on the death certificate as "Embolus to the brain, due to ruptured uterus, due to the previous section."

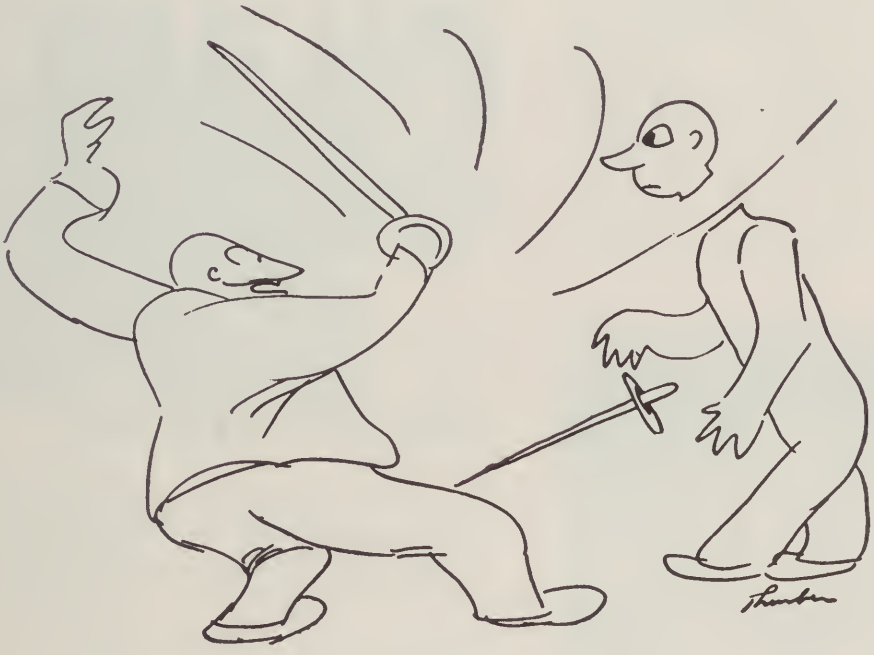
Comments

This case was selected to call attention to a persistent and seriously handicapping problem: the unavailability of enough specific information to make possible adequate evaluation of the various circumstances responsible for maternal deaths. The committee classified this as a direct obstetrical death with possible preventable factors, although the scanty information supplied made intelligent comment difficult. It was pointed out that the cause of death as stated on the certificate, namely "embolus to the brain due to rupture of the uterus," would have been anatomically impossible.

Since the indications for the initial section were not given, it cannot be dogmatically stated that a low cervical section should have been done rather than a classical operation; the former is usually considered preferable from the standpoint of prevention of subsequent rupture of the uterus. In several clinical situations, the classical incision is specifically preferable for technical reasons. These include transverse lie and placenta previa in which the placenta is implanted on the anterior wall of the lower uterine segment.

The uterine scar of a previous cesarean section remains the largest single predisposing factor to spontaneous rupture of the uterus. A successful outcome depends on a combination of rapid diagnosis and prompt specific treatment. Whenever the diagnosis of ruptured uterus is suspected, the patient represents an acute obstetrical emergency. At laparotomy, the most direct and expedient method of controlling the maternal hemorrhage should be applied. In most cases, a rapid subtotal hysterectomy is the operation of choice. When there is laceration of the broad ligaments with hematoma formation, and accurate identification of the uterine vessels is impossible, ligation of the internal iliac artery on the involved side may be life-saving.

The most important single circumstance leading to prevention of rupture of the uterus lies in the use of rigorous criteria in determining the indications for all first cesarean sections.



"Touché!"

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For a better way to treat headache,
prescribe **Trancoprin®**

How Trancoprin relieves pain: Because most pain is accompanied by muscle spasm and tension, good medical practice suggests use of an analgesic that will relax skeletal muscles as well as dim pain perception. Such an analgesic is Trancoprin — a combination of aspirin and Trancopal®, a proved, safe, skeletal muscle relaxant and tranquilizer. Trancoprin can be prescribed for any pain, except pain of such severity that a narcotic is needed.

Dosage: Adults, 2 tablets three or four times daily; children (5 to 12 years), 1 tablet three or four times daily. Each tablet contains 300 mg. of aspirin and 50 mg. of Trancopal (brand of chlormezanone). Bottles of 100 tablets.

Winthrop LABORATORIES
New York 18, N.Y. 1972M

in abdominal distention

Associated with air swallowing, functional indigestion, spastic colitis, diverticulitis, peptic ulcer, postoperative gas.

NEW SILAIN T.M.

The original brand of methylpolysiloxane



FOAM BEFORE SILAIN

FOAM AFTER SILAIN

a gastrointestinal DEFROTHICANT*

Air swallowing, abnormal peristalsis or "nervous indigestion" accelerates foaming. Foam and froth increase the volume of gastrointestinal contents causing discomfort.

SILAIN *dispels foam and froth*

Even normal peristalsis may produce thick, viscous foam in the presence of gastric mucin and gas forming digestive processes.

SILAIN *reduces increased volume*

By lowering interface cohesion, SILAIN breaks down the gas bubbles reducing the foam to a liquid.

SILAIN *provides fast relief*

Relief occurs promptly when foam is broken—entrapped gas is liberated for normal absorption or eliminated by belching or passing flatus—volume decreases immediately.

SILAIN *is safe*

A single non-toxic compound, SILAIN acts physically with no effect on gastrointestinal motility.

FORMULA: Each tablet contains 50 mg. methylpolysiloxane.

DOSAGE: 1 or 2 tablets after meals or more frequently if necessary.

AVAILABLE: 50 mg. tablets in bottles of 100.

Clinical trial supply on request

*DEFROTHICANT—The property of preventing and eliminating foam.

U. S. Patent No. 2,951,011

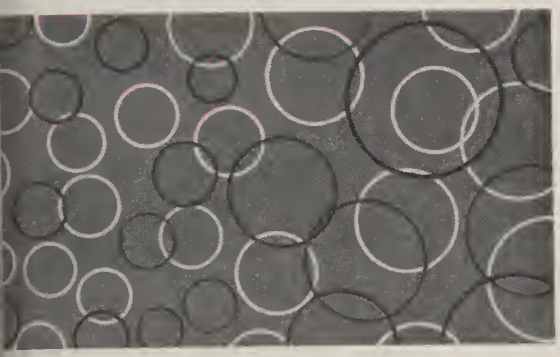
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in peptic ulcer, hyperacidity, heartburn

Control Gastric

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TABLETS

NEW SILAIN-GEL T.M.

DEFROTHICANT ANTACID

SILAIN-GEL *non-fatiguing, fruit-mint taste*

Releases Gas—The unique physical property of SILAIN breaks the frothy bubbles liberating the gas for elimination.

Neutralizes Acid—Specially balanced antacid formulation provides efficient neutralization.

DOSAGE—2 tablets after meals and at bedtime. The safety of Silain-Gel permits administration as often as necessary.

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PUBLIC HEALTH PAGE

The Story Of Civil Defense 200-Bed Emergency Hospital Units

RUSSELL E. TEAGUE, M.D., M.P.H. *Commissioner of Health Commonwealth of Kentucky*

AN enemy bombing of any large Kentucky city would bring devastating results. In addition to the immediate fatalities, thousands of people would be seriously injured. Some would become surviving casualties, while many more would die later surviving only the first hours after the attack.

Those of us who escape would be faced with the responsibility of caring for these people—the burned, the crippled, the maimed—who would need hospitalization.

If our cities are evacuated in anticipation of such an attack, more people would be injured during their flight to relative safety. These casualties would require hospitalization in reception areas.

Over and above all these injured, the normal number of sick and injured of any community would remain constant, if not increased, as a result of added mental and physical stress.

Not one Kentucky community would have enough medical facilities to care for so many people all needing treatment at virtually the same time.

Larger hospitals—located within target areas and in zones of complete destruction from a thermonuclear weapon—would not be available for casualty care. As a result, existing hospital facilities outside of blast areas would be quickly filled to overflowing.

In order to provide additional hospital facilities for these possible casualties, the State Division of Civil Defense and State Health Department, through the Office of Civil and Defense Mobilization, have obtained twenty-one 200-bed emergency hospitals, stockpiled equipment and supplies, and developed plans for their use in time of enemy attack.

The 200-bed unit is intended to provide such hospital care as initial treatment and emergency surgery. It also may be made available to the State or its political subdivisions for use in a major disaster upon the specific authorization of the regional OCDM director.

The success of these plans for saving lives in time of emergency depends upon how well local personnel are trained to set up and operate these facilities. uncrated, assembled, and put into operation quickly

When the emergency hospital is needed, it must be uncrated, assembled, and put into operation quickly and effectively. It is therefore necessary that professional medical, as well as non-medical, personnel understand the composition of the hospital unit. Not only should they familiarize themselves with the supplies and equipment with which they will work, but they should also be trained in their use.

With this purpose in mind the Civil Defense Authority and the State Health Department have provided a hospital to help train medical officials, hospital staff members and other technical and non-technical personnel. Because of its restricted use, this unit comprises only the principal working elements of a civil defense emergency 200-bed hospital.

In time of emergency, casualties will receive medical treatment first at one of several casualty stations located as close as possible to the blast area or scene of disaster. Each station will be manned by evacuating medical personnel or one or more of the mobile medical teams organized within the state.

During this time workers will be setting up emergency hospitals in certain communities as instructed by the co-director for health services. After clearing the building they will position equipment in predetermined locations according to hospital sections.

At the same time, the skelton staff organized to place the hospital into operation will arrive and make preparations to receive the severely injured.

The most practical building for this purpose in a typical community is a school building of recent design (not more than two stories, with or without a basement).

Valued at $26,139.21, the 200-bed emergency hospital consists of 367 cases containing more than 8,000 individual pieces. It weighs 24,000 lbs. and occupies approximately 15,000 square feet of space when assembled.

Each hospital is designed so that it can be set up in about four hours time by some 30 professionals and semi-trained auxiliaries with the assistance of untrained volunteers.

This article was prepared by Forrest D. Stokes, Director, Division of Health Mobilization, Kentucky State Department of Health, Frankfort, Kentucky

Staffing the hospital for a 24-hour period would require the services of 305 persons. Here is a brief description of each section:

Sterilizing Room: Equipment includes nine dressing sterilizers of the pressure cooker type and six boiling sterilizers which may be heated either by gasoline or liquefied petroleum (bottled) gas. This section will be set up first since instruments for the operating rooms will have to be sterilized immediately.

Reception and Sorting (Triage) Rooms: Casualties will be received in this section and then sorted according to type of injury. Records will be made and personal effects collected and tagged.

Emergency lifesaving treatment will be given in the sorting area (shock room) which is equipped for such emergencies. Minor surgical work will be performed here to cut down the number of cases waiting for a turn in the operating room. In other instances, however, casualties will be distributed to one of the wards and/or operating rooms. For this reason the shock room should be located near the operating rooms.

Operating Rooms: Equipment for this section consists of three operating tables, three sets of anesthesia apparatus, three operating room lights and the instruments, stands, and other supplies necessary for lifesaving surgery.

Wards: The number and capacity of each ward will be designated by the medical person in charge; they will depend on the type of casualties received.

As time elapses and the numbers of patients increase, the hospital staff also will increase, with assignments being made by the state co-director for health services from evacuated medical personnel reporting into welfare centers. Likewise, the efficiency of service would increase as time passes and personnel become better acquainted with their duties.

Laboratory: A clinical laboratory containing equipment and supplies for carrying out different standard clinical tests is included in a small compact cabinet. Tests would include blood typing, determination of hemoglobin, testing the clotting time, routine urinalysis, etc.

X-Ray: The field X-ray equipment is similar to that used by the armed services. Adapted for fast work, involving both photography and fluoroscopy, it utilizes the Land 60 second process of developing X-ray plates. The machine is equipped with its own portable generator and transformer.

Pharmacy: Supplies include antibiotics, heart and respiratory stimulants, intravenous solutions and other items. A minimum of compounding would be required since practically all materials would be ready for use.

Central Supply: Used for preparation and storage of supplies and equipment, this area would include surgical instruments and expendable supplies sufficient for 36 to 48 hours of operation.

Administration: The hospital depends upon the whole vast organization of civil defense from which it obtains food, general supplies, utilities, services, policing and transportation. An administrative office must be established, however, to correlate these outside activities with the needs of the hospital and to give general direction within the unit.

In The Books

(Continued from Page 918)

of renal disease and etiologic types of heart failure.

In all, this is a good introductory text for the student and the nonspecialist. It will be useful in summarizing and applying new data in this swiftly moving field. It should serve, too, to stimulate further reading of some of the original sources.

E. D. Pellegrino, M.D.

Enrollment in the 75 Blue Shield Plans serving North America reached 47,953,005 on March 31, 1961. This represents an enrollment of one out of every four Americans, and nearly 15 per cent of the total Canadian population. The National Association of Blue Shield Plans also reports that 14 Plans have enrolled more than 40 per cent of the population in the areas they serve. Enrollment in Kentucky reached 716,137 on June 30, 1961.

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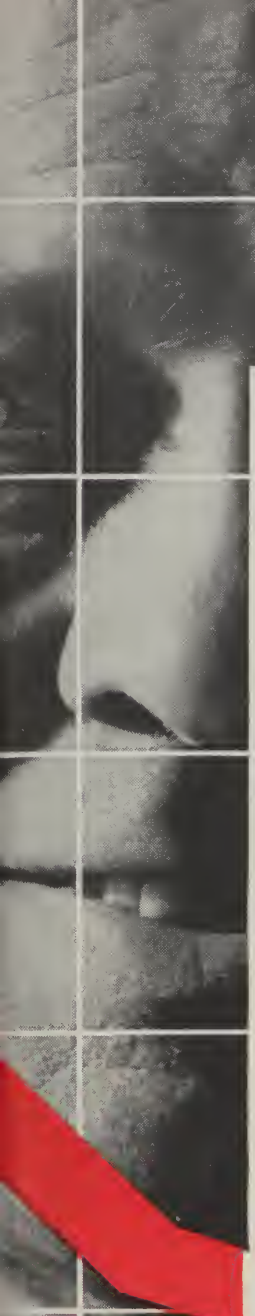
of course it is, though some have called it "education" . . . not <u>really</u> "advertising."

Of course it's "advertising"... a frankly competitive activity of the American private enterprise system to which this industry belongs. Of course it's "advertising"...created in the hope of getting the physician to note and read; of persuading him, by setting forth proven indications and advantages, to learn about a drug; and of thereby helping him alleviate suffering or cure disease by prescribing it.

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There's been a lot of talk about "over-advertising", and there may have been occasional excesses. But consider the potential dangers, in this era of astonishing new drugs, of "under-advertising"... in view of the complexity of modern drug therapy; the lag of 6 to more than 18 months before the appearance of definitive medical articles on new drugs; and the fact that there is no other source of such comprehensive information about a new agent as the company that ran it through the crucial gauntlet of animal pharmacology and clinical investigation.

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Caesarean Section in Breech Presentation

(Continued from page 878)

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Special Article

(Continued from page 880)

about prepayment plans and their differences, and that they advise their patients on the choice of such plans.

John Dickinson, M.D.

The Trustees of America's oldest medical essay contest, the Caleb Fiske Prize of the Rhode Island Medical Society, announce two subjects for this year's dissertation: "Recent Advances in the Treatment of Malignant Disease," and "Current Status of Cardiac Surgery." A cash prize of $500 will be awarded the winning essay, open to any doctor of medicine in the nation. Essays must be submitted by December 11, to the Secretary, Fiske Fund, Rhode Island Medical Society, 106 Francis Street, Providence 3, Rhode Island.

The American College of Chest Physicians will hold its annual Interim Session at the Brown Palace Hotel in Denver, Colo., November 25-26. Scientific sessions will be held Saturday morning, November 25, and Sunday afternoon, the 26th, at which two Louisville doctors will speak. They are: Oren A. Beatty, M.D., and Alvin B. Mullen, M.D. Meetings of the Board of Regents and Board of Governors will be held on Saturday afternoon and will be attended by John S. Harter, M.D., Louisville, an officer of the College.

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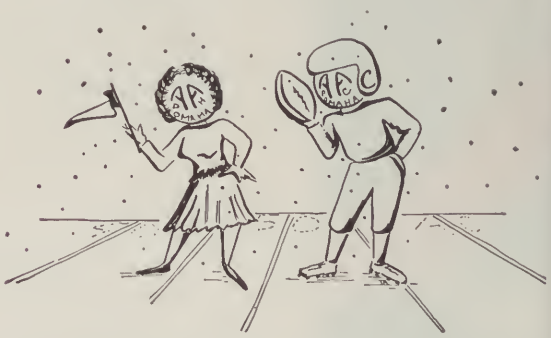
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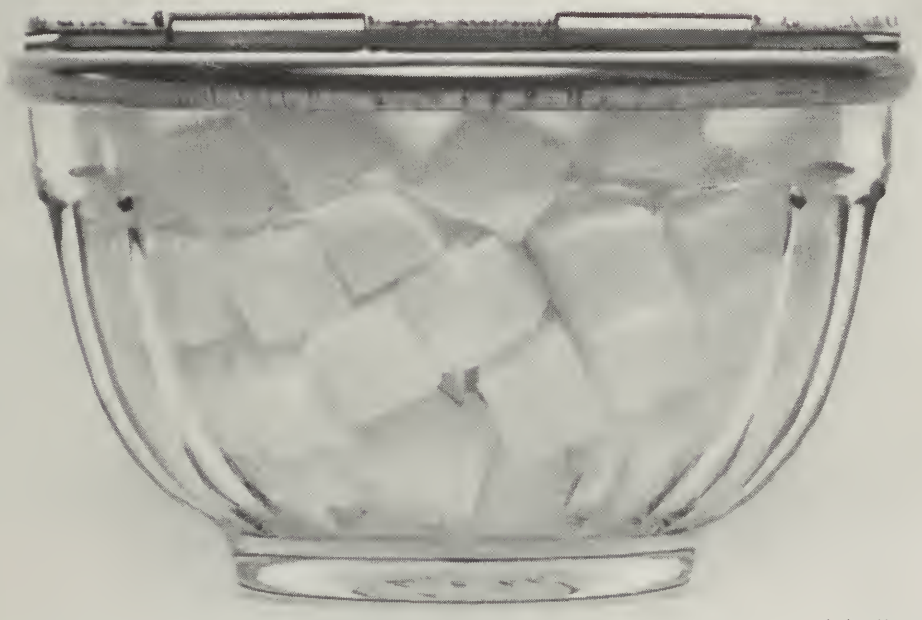
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Symposium on Some Recent Advances in Renal Disease

Complete Contents on Page 938

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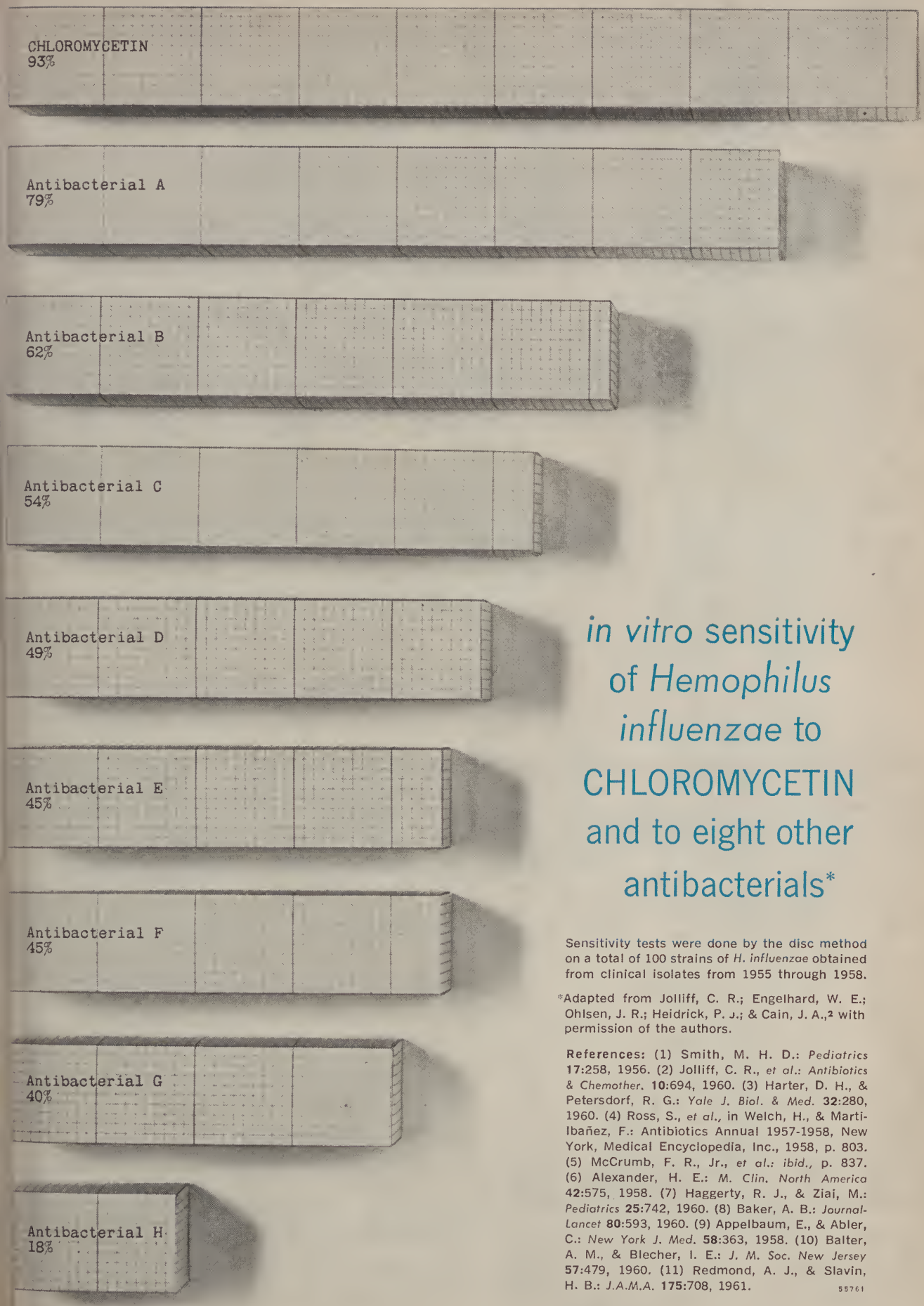
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Precautions: It is essential that adequate blood studies be made during treatment with the drug. While blood studies may detect early peripheral blood changes, such as leukopenia or granulocytopenia, before they become irreversible, such studies cannot be relied upon to detect bone marrow depression prior to development of aplastic anemia.

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*Adapted from Jolliff, C. R.; Engelhard, W. E.; Ohlsen, J. R.; Heidrick, P. J.; & Cain, J. A.,[2] with permission of the authors.

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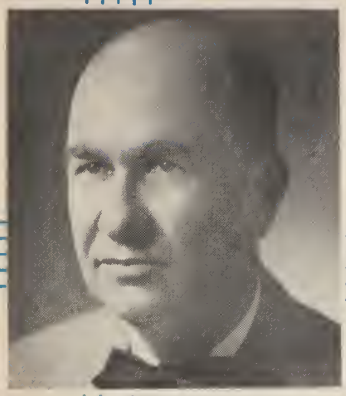
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MESSAGE FROM THE PRESIDENT

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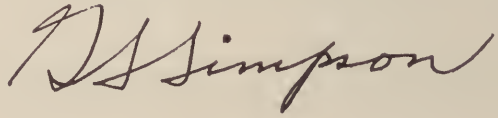
The physician is Scientist, Artist, and Public Servant. Modern medicine is based upon scientific study and the application of results thus obtained, and constantly changes by discovery of new approaches through an understanding of illness and injuries and their treatment. There is a desirable, although dispensable, degree of art and finesse in the manner in which a physician applies his professional skills to the problems of his patients. As public servants we are expected to have available our services in all times and places of need.

There is abundant evidence that scientific medicine in Kentucky improves constantly. (We are possibly somewhat less adept in the art of the practice of medicine than our medical forefathers were.) In the matter of an equitable distribution of physicians to patients in the cities as contrasted to that in the smaller urban and rural areas, affecting availability, we are in a less desirable position.

These facts are pertinent:

1. There is a perceptible shift of rural people including physicians to larger urban areas.
2. The distribution of physicians, as with other citizens, must be voluntary.
3. Approximately 60 to 70 per cent of U. of L. medical graduates now enter specialties.
4. Many physicians with allied groups in rural Kentucky practice a specialty satisfactorily and see minor illnesses outside their field, referring the more seriously ill to the proper consultant in the group.
5. The KSMA Rural Scholarship Fund and the Physician's Placement Agency have established a considerable number of physicians in rural Kentucky.
6. The KAGP has been a factor in attracting physicians to small urban areas.
7. The U. of L. has a series of lectures which promote the generalists.

Apparently a satisfactory solution to the problem of unequal distribution of the physicians to patients throughout Kentucky has not been found. If those of us who wish to see the practice of medicine remain a free enterprise are not willing or able to solve this knotty problem, it may be ultimately solved by others in a manner not pleasing to us.





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*Gamble, C. J.: Am. Pract. & Digest Treat. *11*:852 (Oct.) 1960. See also Berberian, D. A., and Slighter, R. G.: J.A.M.A. *168*:2257 (Dec. 27) 1958; Olson, H. J.; Wolf, L.; Behne, D.; Ungerleider, J., and Tyler, E. T.: California Med. *94*:292 (May) 1961; Kaufman, S.A.: Obst. & Gynec. *15*:401 (Mar.) 1960; Warner, M.P.:J.Am. M. Women's A. *14*:412 (May) 1959.

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1. Youmans, J. B.: Am. J. Med. 25:659 (Nov.) 1958

cardiac diseases "Who can say, for example, whether the patient chronically ill with myocardial failure may not have a poorer myocardium because of a moderate deficiency in the vitamin B-complex? Something is known of the relationship of vitamin C to the intercellular ground substance and repair of tissues. One may speculate upon the effects of a deficiency of this vitamin, short of scurvy, upon the tissues in chronic disease."[2] 2. Kampmeier, R. H.: Am. J. Med. 25:662 (Nov.) 1958.

arthritis "It is our practice to prescribe a multiple vitamin preparation to patients with rheumatoid arthritis simply to insure nutritional adequacy . . ."[3]
3. Fernandez-Herlihy, L: Lahey Clinic Bull. 11:12 (July-Sept.) 1958.

digestive diseases Symptoms attributable to B-vitamin deficiency are commonly observed in patients on peptic ulcer diets.[4] Daily administration of therapeutic vitamins to patients with hepatitis and cirrhosis is recommended by the National Research Council.[5] 4. Sebrell, W. H.: Am. J. Med. 25:673 (Nov.) 1958. 5. Pollack, H., and Halpern, S. L.: Therapeutic Nutrition, National Academy of Sciences and National Research Council, Washington, D. C., 1952, p. 57.

degenerative diseases "Studies by Wexberg, Jolliffe and others have indicated that many of the symptoms attributed in the past to senility or to cerebral arteriosclerosis seem to respond with remarkable speed to the administration of vitamins, particularly niacin and ascorbic acid. These facts indicate that the vitamin reserve of aging persons is lowered, even to the danger point, more than is the case in the average American adult."[6] 6. Overholser, W., and Fong, T.C.C. in Stieglitz, E. J.: Geriatric Medicine, 3rd edition, J. B. Lippincott, Philadelphia, 1954, p. 264.

infectious diseases Infections cause a lowering of ascorbic acid levels in the plasma; and the absorption of this vitamin is reduced in diarrheal states.[7] 7. Goldsmith, G A.: Conference on Vitamin C. The New York Academy of Sciences, New York City, Oct. 7 and 8, 1960. Reported In: Medical Science 8:772 (Dec.10) 1960.

diabetes Diabetics, like all patients on restricted diets, require an extra source of vitamins.[8] "Rigidly limiting the bread intake of the diabetic patient automatically eliminates a large amount of thiamin from the diet. . . . There is some evidence of interference with normal riboflavin utilization during catabolic episodes."[9]
8. Duncan G. G.: Diseases of Metabolism 4th edition W. B. Saunders, Philadelphia, 1959, p. 812. 9. Pollack, H.: Am. J. Med. 25:708 (Nov.) 1958.

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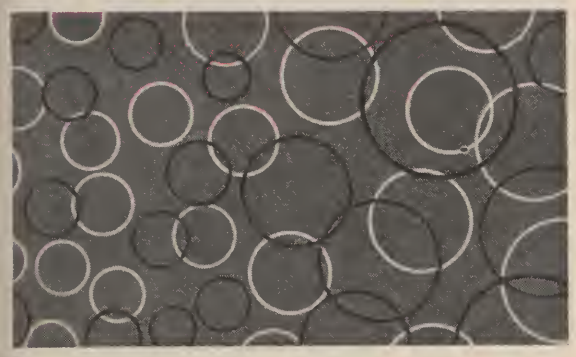
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THE INSURANCE PAGE



The Indiana Plan

AT the meeting of the House of Delegates last month the KSMA adopted the following statement of policy:

"The Kentucky State Medical Association agrees that each County Medical Society may decide for itself whether or not to adopt the Indiana Plan, or any similar plan for the prepayment of medical care."

This statement neither approves or disapproves the Indiana Plan at the state level. It merely supports the right of each component society to set its own policy in this regard.

The basic features of the so-called Indiana Plan are these:

1. The Blue Shield Plan under which it operates is an indemnity type of plan.
2. The decision to accept the indemnity allowances as full payment for certain people is made by the physicians themselves and is implemented by mutual agreement among the physicians. This is done on a county society level and in no way obligates the physicians of adjoining counties.
3. No physician who does not wish to enter into this agreement is obligated to do so either legally or morally.
4. This agreement among the physicians could be abrogated at the end of any contract year by the physicians themselves, if they so desire. It might be said, parenthetically, that we do not know of any county society in Indiana which has withdrawn from this arrangement after adopting it.
5. Any participating physician may refuse to accept the indemnity allowance as payment in full by prior discussion of fees with the patient before rendering the service.

For the past few years, several county medical societies in eastern Kentucky have operated, within the framework of Kentucky Physicians' Mutual Inc., by almost identically such an agreement among their members. This arrangement has never been questioned by any action or policy statement of the Kentucky State Medical Association.

The recent action by our House of Delegates does not, therefore, constitute a change of policy. It merely re-affirms a policy which has long been recognized and must continue to be recognized, that the county medical society is an autonomous organization.

As long as its policies conform to the principles of ethics of the AMA, and are not in violation of the constitution of the KSMA, each society should and must have the right to determine for itself the financial arrangements under which its members are paid for their services.

W. Vinson Pierce, M.D.

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WASHINGTON NEWS DIGEST

Washington, D.C.—The Senate and House approved a multi-million dollar expansion of federal aid to community health services.

The Senate approved it by routine voice vote a few weeks before adjournment. The House earlier had approved a slightly different form of the legislation. No difficulty was anticipated in adjusting the differences of the two versions so that it could become effective at an early date.

Some of the programs covered by the legislation were of special importance to the aged and the chronically ill. Key provisions of the bill would:

—Raise from $30 to $50 million, for five years the annual authorization for matching grants to states and cities for public health services such as home nursing, home health care, and a variety of services to nursing homes.

—Establish a five-year $10 million-a-year program of special grants to non-profit groups for research and development aimed at improved health services given outside the hospital.

—Raise from $10 million to $20 million the annual authorization for construction of public and non-profit nursing homes.

—Extend loan provisions for hospital construction under the Hill-Burton Act until its grant program expires in June 1964.

—Raise from $1.2 million to $10 million the annual ceiling on grants for hospital research and permit grants for experimental or demonstration hospital units.

Extend for three years the matching grant program which provides federal help for construction of health research facilities and authorize $50 million rather than $30 million a year.

Influenza Epidemic Predicted

Luther L. Terry, M.D., Surgeon General of the U.S. Public Health Service, predicted that there will be a new influenza epidemic in the United States this fall and winter.

He urged immediate vaccinations for people over 65, pregnant women and persons with heart diseases and other chronic illnesses.

"We are probably due for some Asian flu outbreaks, since they come in two- or three-year cycles," Terry said, "and we are overdue for type B flu outbreaks which come in four- to six-year cycles."

More than 86,000 people in the three most susceptible groups died from influenza between September 1957 and March 1960. Asian flu has been dormant in this country since then. It has been more than six years since type B flu has been widespread.

Both types of flu were prevalent in other countries in 1960-61, especially in England. In 1951, when England had a similar epidemic, flu reached this country the following year, Terry noted.

The U.S. Public Health Service is alerting physicians, state health officers and welfare agencies to include flu shots in their programs of public assistance.

Live Virus Polio Vaccine Licensed

The Type I oral, live virus polio vaccine developed by Dr. Albert Sabin has been licensed by the U.S. Public Health Service for marketing in the United States.

However, the PHS, the American Medical Association and others urged that the widest possible use still be made of the Salk killed vaccine. The principal use of the newly licensed oral vaccine this year will be against epidemic threats of Type I polio.

The license for manufacture of the oral vaccine was granted to Pfizer, Ltd., Sandwich, England, and it is being marketed in this country by Chas. Pfizer & Co., Inc., of New York.

Luther L. Terry, M.D., Surgeon General of the PHS, said he expected Type II oral vaccine to be licensed soon but that it would be several months before Type III would be licensed.

Pfizer is expected to have more than 50 million doses of the Type I oral vaccine available for use by next spring at the start of the 1962 polio season. For an epidemic reserve, the PHS ordered at the time of the licensing a total of 900,000 doses of the Type I vaccine in frozen form at a cost of $81,000.

Information on the terms for obtaining vaccine from this epidemic reserve was sent to State and Territorial Health Officers. The requirements include:

At least three cases of Type I polio in the community within a month, of which two have been confirmed to be Type I by laboratory anslysis.

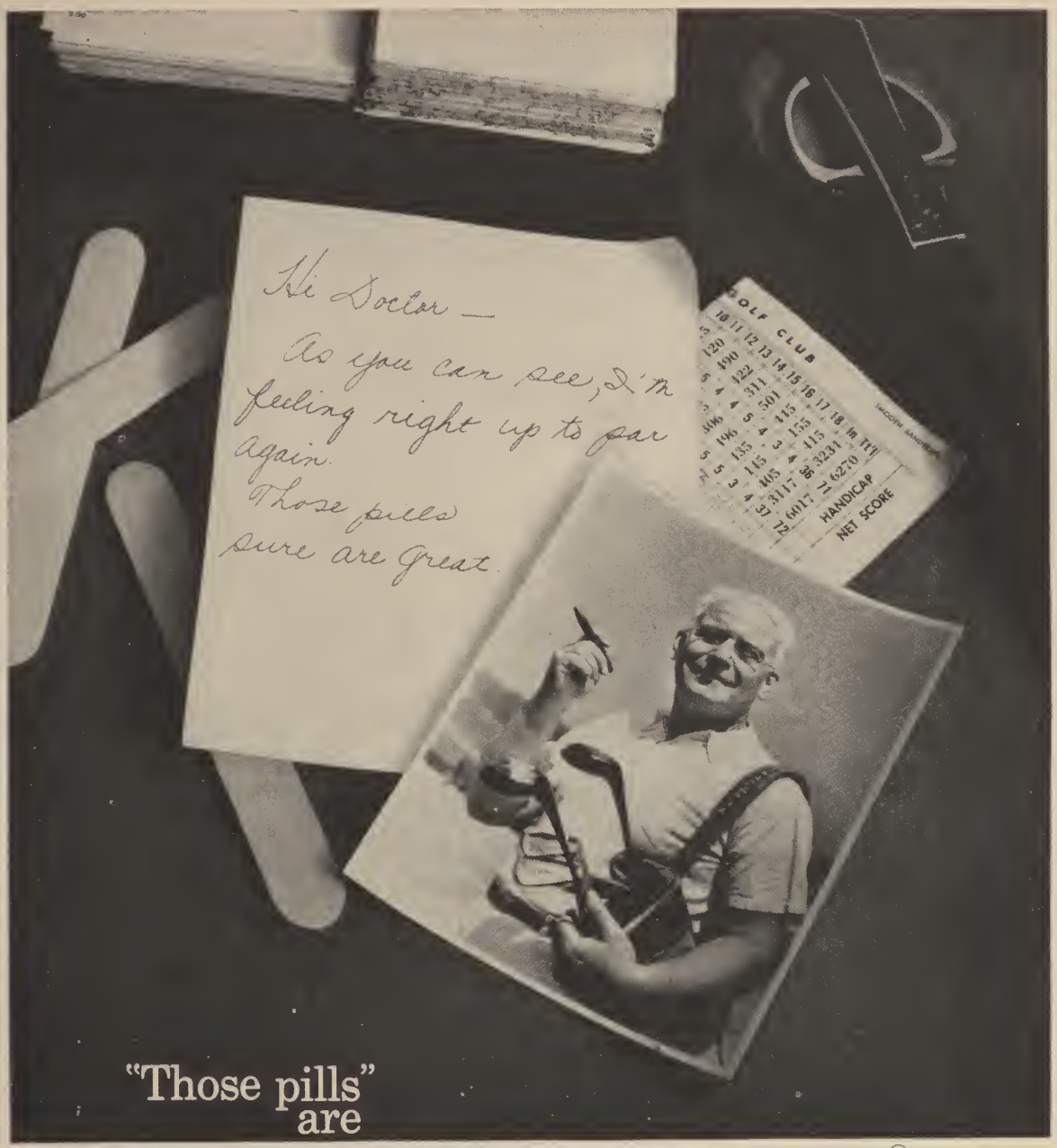
Adequate community organization and medical leadership to insure rapid and complete coverage of the population under 50.

Agreement to make the vaccine available without charge to persons under 50.

All local requests must be channeled through State health departments.

Of the three types of polio virus, Type I has been responsible in recent years for between 60 and 70 per cent of all paralytic polio in this country, PHS said. However, a sampling of virus isolated from paralytic cases this year suggests that Type III may be increasing in relative importance as a cause of paralytic disease.

(Continued on Page 1013)



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Linoleic Acid	13.6 Gm.
Vitamin A (Adult's Need)	47%
Vitamin A (Child's Need)	62%
Vitamin D (Adult's and Child's Need)	62%



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Case history courtesy of Joel Goldman, M.D., Johnstown, Pa. These photographs of Dr. Goldman's patient were taken on November 10, 1960.

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Symposium on Some Recent Advances In Renal Disease

The Streptococcus and Kidney Disease

KINGSLEY M. STEVENS, M.D.*

Lexington, Ky.

TWO extensive reviews of glomerulonephritis have been published during the last two years and the reader is referred to them for comprehensive information.[1,2] This report will summarize the current status of the problem as evaluated by the author. Only the acute disease will be considered; the chronic disease is more protean and correlates poorly with experimental work.

Historical Review of Relation of Streptococcus and Nephritis

Bright,[3] in 1827, noted that scarlatina, now known to be a streptococcal disease, could produce renal disease. In 1880 Kannenberg[4] reported a correlation between tonsillitis and nephritis. Eleven years later, Mannaberg[5] isolated bacteria from patients with scarlatina. He identified these as streptococci and claimed that he produced nephritis in dogs and rabbits with cultures of this organism. In 1912 Schick[6] suggested that acute glomerulonephritis might represent a hypersensitivity reaction to streptococci.

Forty years later Rammelkamp and Weaver[7] presented evidence that a specific strain of streptococci, group A, type 12, was responsible for most cases of the disease. In 1958 Kelly and Winn[8] placed nephritogenic type 12 streptococci into a diffusion chamber in the peritoneal cavity of mice. This chamber allowed free passage of molecules, retained bacteria, and prevented the entrance of body cells. Such mice showed renal lesions a week to ten days later; other strains produced no lesions. Reed and Matheson,[9] using rabbits, produced hypertension and kidney lesions with a dialysate from a type 12 culture; a type 17 culture was inactive.

Another approach, with a long history, is the production of nephritis with foreign antikidney serum, first demonstrated by Lindemann[10] in 1900. In this system, kidney from

The Journal of KSMA presents its fourth annual Scientific Symposium with Edmund D. Pellegrino, M.D., Lexington, as Special Symposium Editor. Doctor Pellegrino is professor and chairman of the Department of Medicine, University of Kentucky College of Medicine.

*Department of Medicine, University of Kentucky College of Medicine. Recipient of Lederle Medical Faculty Award.

species A is injected into species B and the anti-serum obtained from species B injected into species A intravenously. The important antigen in the kidney has been shown to be in the glomerular basement membrane[11,12] although it is also found in lesser concentration in other organs, such as lung.[13] Anti-kidney antibodies localize fairly specifically to the glomerulus.[14] Nephritis produced with heterologous antiserum has been extremely difficult to interpret and evaluate. With potent antiserum, the reaction is almost immediate.[15] However, since the serum is foreign, antibodies are formed to it. These react with residual antibodies (now functioning as antigen) causing further kidney damage. Furthermore, large doses of normal serum produce nephritis[16] although no specific affinity for the kidney would be anticipated.

Attempts to produce nephritis with homologous kidney have been unsuccessful.[17,18] However, whole perfused kidney rather than basement membrane was used as antigen, and it appears likely that one group discarded the basement membrane in centrifugation.[18]

Some workers have tried to produce nephritis with combinations of homologous kidney plus streptococci. The Caveltis[19] produced nephritis in rats with such a combination, but other workers have been unable to confirm these results.[20,21] Although the concept that glomerulonephritis might represent an auto-immune disease was introduced by Schwentker and Comploier in 1939,[22] these workers did not look for nephritis. Instead they measured the formation of complement fixing antibodies to kidney after immunization with homologous kidney incubated with streptococcal or staphylococcal toxin.

The positive information, concerning the disease in man, includes the following: 1. Infection by certain strains of group A, type 12 streptococci is followed one to three weeks later by acute glomerulonephritis. However, other types (especially 4 and 25) may also cause the disease, and all patients with an overt infection with a nephritogenic strain of type 12 do not develop glomerulonephritis. 2. If very sensitive techniques are used, patients with acute nephritis or nephrosis usually show circulating anti-kidney antibodies.[23,24] 3. Patients with acute glomerulonephritis show the presence of human-gamma-globulin, presumably antibody, attached to the basement membrane of the glomerulus.[25] 4. Patients with acute nephritis have a low serum complement,[26,27] suggesting an antigen-antibody reaction. This is also found in experimental nephritis produced with nephrotoxic serum.[28]

Possible Immunologic Mechanisms

Three hypotheses will be considered in the pathogenesis of this disease. The first would postulate that the type 12 streptococcus contains a haptene which combines with a protein in the basement membrance. The protein is considered as "self" and is not antigenic. The complex, however, is antigenic, with the specificity determined by the foreign haptene. Antibodies are formed to this antigen, and such antibodies will react with both the free haptene and the complex. Reaction with the complex in the kidney produces the pathological changes. In time the complex is degraded and the cycle broken. The chief weakness of this theory would appear to be the finding that patients with acute nephritis or nephrosis have antibodies to normal kidney tissue, without any requirement for streptococcal contact or products.

A second hypothesis would postulate that the type 12 streptococcus contains an antigen identical with one found in the basement membrane. This assumes that the basement membrane contains a substance which is antigenic in the host, but not accessible to the circulation. The specific soluble streptococcal antigen induces antibody, which then reacts with the specific antigen found in both the streptococcus and in the basement membrane. If this is so, then a type 12 culture should be capable of selectively removing antibody produced with basement membrane.

A third hypothesis would postulate that type 12 streptococci produce a substance, probably an enzyme, able to solubilize basement membrane. As in the preceding hypothesis, it is assumed that basement membrane is antigenic, but, like lens, is not normally available to antibody-forming cells. The antibody formed would be directed against the appropriate antigen in the kidney or elsewhere and would be unrelated to the streptococcus. Of course, as a separate system, antibodies would be formed against various antigenic components of the streptococcus. If this mechanism is valid, then

basement membrane alone, given appropriately, should produce nephrotoxic antibodies in homologous (or even autologous) animals. In addition, the streptococcal product should not adsorb antibody so produced.

Penicillin—Use in Treatment and Prophylaxis

Although the role of the streptococcus remains undefined in this disease, it clearly plays a critical part in the development of the acute disease in the majority of cases. Since no specific therapy is available for glomerulonephritis, prophylaxis should center on the streptococcus. Although the disease is primarily instigated by a type 12 stain, there is no clinical method for determining types, and laboratory determinations are usually unavailable or impractical. Furthermore, the physician is usually more concerned about rheumatic fever, caused by many types, than about glomerulonephritis. Hence treatment is directed toward Group A streptococci, and the drug of choice, from the viewpoint of effectiveness and economy, is penicillin.

A: Allergic Responses to Penicillin

Even though penicillin is the most effective drug, it is desirable to consider, in some detail, the incidence of allergic reactions to this antibiotic.[29] While it is impossible to obtain accurate figures, well over 100 deaths due to penicillin have been reported in readily available journals. The figure is undoubtedly much higher, perhaps close to 1000.[30] The only adequately reported death due to oral penicillin[31] was that of a two-year-old girl who had received oral penicillin at one year of age. In contrast to this, all the other severe reactors to oral penicillin had previously received parenteral penicillin.[32-37] In three large-scale studies of military groups, involving over 60,000 subjects, reaction rates were about 0.9% for men receiving intramuscular penicillin, compared with 0.1% to 0.3% for those receiving the oral medication.[38-41] Of more importance, the reactions to the oral drugs were much less severe, and no anaphylactoid cases were reported. Again almost all patients, having reactions to the oral drug, had previously received intramuscular penicillin. A review of all reactions to penicillin observed in the United States Navy between 1951 and 1954 showed a direct correlation to the amounts of parenterally administered penicillin but not to oral penicillin.[42] Almost all studies on penicillin reactions confirm the finding that patients with allergies of any type have more frequent and more severe reactions to penicillin.

The lessened intensity of penicillin reactions to the orally administered drug is consistent with the general picture of anaphylaxis, *i.e.*, fatal anaphylaxis usually requires intravenous injection of antigen. As far as I can determine, experimental fatal anaphylaxis has *never* been produced when both sensitizing and shocking doses of any antigen were given orally.

The preceding emphasizes the importance of determining the allergic history of the patient, especially in regard to penicillin reactions. In any case where a penicillin reaction has occurred, the drug should not be used, except orally, and then only if antibiotic therapy is urgently needed and no other drug could be substituted. Skin testing is not the answer in these cases, or in others for that matter. It is cumbersome, requires parenteral introduction of the drug which may produce severe reactions, and skin reactions may be negative although the patient subsequently reacts adversely to penicillin.[43-46]

In the case of any drug where allergic reactions run in the 1% and higher range, it appears clear that we are dealing with hypersensitivity rather than a rare idiosyncracy. The meaning of this, presumably, is that about 1% of the population at this time produce enough antibodies to penicillin so that subsequent introduction of antigen (or haptene) produces an antigen-antibody reaction of sufficient intensity to be manifested as a clinical syndrome. The percentage of sensitive individuals is certainly higher for hospital populations. An allied term to hypersensitive is hyperimmune. In the former, we select a fairly random group and designate the top reactors as hypersensitive. In the latter case, we take a random group and repeatedly immunize them so that all, or essentially all, of the group behave as did the hypersensitive group. The implications are fairly clear. Penicillin has been in general use only 15 years, and we are gradually hyperimmunizing the population to this drug. Hence the incidence of hypersensitivity should also continue to rise. Consistent with this is the lower incidence of penicillin sensitivity in children.[47]

The treatment of anaphylactic reactions should probably revolve around epinephrine and oxygen, since the immediate problems are those of hypotension and inadequate oxygen exchange. While antihistaminics and steroids have been widely used, their value in the acute condition is questionable. A patient on a maintenance dose of prednisolone (5 mgm t.i.d.) developed an anaphylactic reaction to penicillin.[48] There are usually no contraindications to antihistaminics or soluble steroids, but the first drug obtained should be epinephrine. It should be mentioned that penicillinase has been used to treat penicillin reactions, but this may itself produce an anaphylactic response.[49-51]

Our viewpoint in the treatment of streptococcal pharyngitis will be based on the assumption that penicillin is the most effective drug, but that its use requires consideration of the findings mentioned earlier. In general, patients with streptococcal pharyngitis show more exudate, higher fever, higher white count (over 12,000) and more frequent vomiting than patients with viral pharyngitis.[52] Tender lymph nodes are also more common. However, certain cases of adenovirus infection have shown all these signs and symptoms, so this is not absolute. If few of these signs and symptoms are present, no antibiotic therapy should be initiated. If most are present, a throat swab should be obtained, and a careful history for allergy and prior penicillin reactions elicited. If neither is present, the patient should be started on oral penicillin.

B: Available Preparations

It is now necessary to consider the oral preparations available. In recent years, phenoxymethyl penicillin (penicillin V) has often been considered the oral preparation of choice. This has been based on the well established findings that penicillin V produces higher peak blood levels than other oral penicillins. This difference is most marked during the first hour, when penicillin V levels are about twice those of penicillin G.[53-60] Absorption of both types of penicillin is lower after meals, but buffering increases the absorption of penicillin G when given after meals.[61-62] High blood levels in the order of 1 unit/ml are of no added value since maximal anti-streptococcal activity is found at 0.05 units/ml.[63] There are no other advantages of penicillin V over penicillin G than those described. About 250 mg of penicillin V q 8 h will be required to maintain a level of 0.05 units/ml or over in adults; 250 mg of penicillin G q 6 h give similar results. In children, the 125 mg tablets produce suitable levels.[60] The choice of drug, therefore, becomes a problem of economics. When obtained from the leading drug houses, 250 mg tablets of buffered penicillin G wholesale at 15c apiece, or more; penicillin V costs about 30c each. If 3 tablets of penicillin V are required daily for 10 days, this results in a wholesale price of $9.00. If 4 tablets of penicillin G are required daily, the total figure is $6.00. This is not a huge difference, since the dosage schedule for penicillin V is more convenient than the one for penicillin G. However, it should be noted that buffered penicillin G tablets can be bought quite cheaply. An eastern distributor sells 250 mg tablets for $0.0175 each, or a total of 70c for the 10 day course. With these brands, 500 mg q 6 h might be the preferred dosage.

C: Recommended Dosage Schedules

Returning to the problem of specific therapy, the adult patient with symptoms of streptococcal pharyngitis should be started on oral, buffered penicillin G, 250-500 mg q 6 h, or penicillin V, 250 mg q 8 h. If the throat culture shows no Group A streptococcus, the oral drug would be continued through 3 days. If Group A streptococci are cultured, an adult should receive a single dose of 1,200,000 units (720 mg) of benzathine penicillin G intramuscularly; children receive 600,000 units. Allergic individuals with no prior penicillin reactions would be continued for 10 days on oral penicillin. Known penicillin sensitive patients are probably best treated with erythromycin, 250 mg q.i.d. for 10 days.

The treatment suggested above is an attempt to steer between the Scylla of rheumatic fever and glomerulonephritis, and the Charybdis of penicillin sensitization and anaphylaxis. For the direct treatment of streptococcal pharyngitis, there is rarely adequate justification for parenteral penicillin; an acute attack will usually produce sufficient symptoms so that oral therapy would be continued. However, when eradication of the streptococci is desired, a 10 day treatment period appears necessary, and keeping patients on an oral medication in the absence of symptoms is difficult. Hence, al-

though the use of oral penicillin for prophylaxis of rheumatic fever and glomerulonephritis after streptococcal pharyngitis would appear to be considerably safer, it does not seem practical to advocate its general use for a 10 day period, if B-hemolytic streptococci are isolated.

When a throat culture is not practical, clinical judgment is even more taxed. If the picture appears compatible with streptococcal disease, the patient might be started on oral penicillin and the course of the disease followed. Patients who are seen early and are greatly improved the following day probably do not represent streptococcal infection; this would occur most often in children. If the patient remains sick, but improving, then penicillin should be continued orally, or an intramuscular injection given. In the absence of cultures, it is clear that overtreatment, especially by the parenteral route, will be more common if the above criteria are used.

Summary

1. Current theories of an immunologic etiology of acute glomerulonephritis are considered.

2. Reactions to parenteral versus oral penicillin are reviewed from an immunological viewpoint.

3. A suggested treatment schedule for streptococcal pharyngitis is presented. Emphasis is placed on the use of oral penicillin, with parenteral penicillin used only when Group A, B-hemolytic streptococci are isolated.

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Some Comments on Percutaneous Punch Biopsy of the Kidney

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SINCE the introduction[1] of percutaneous renal biopsy techniques, many papers dealing with the subject have appeared. The technique is useful for many purposes, only two of which will be discussed here: first, as an aid in diagnosis in difficult clinical problems; and second, as a means of increasing our knowledge of the changing structure of the kidney during the course of a disease. Several papers dealing with techniques are listed in the bibliography.[1, 2, 3, 13]

Risks

The chief danger appears to be that of hemorrhage. A small amount of bleeding probably occurs following any renal puncture and is usually negligible. Occasionally massive hemorrhages occur. Uncontrolled hemorrhage is the chief cause of death following biopsy. Patients with bleeding defects, those receiving anticoagulant therapy, and hypertensives are more prone to this complication. Arnold and Spargo[4] estimate that the mortality of the procedure will prove to be less than 0.1 per cent with good technique and careful selection of patients. Brun and Raascho[5] report no deaths in 500 punctures. Kark et al.[3] also report no deaths in 500 punctures and discuss their experience with complications.

Pain may occur following puncture, but it is usually mild and transient. Microscopic hematuria is common but clears in 36 hours. Occasionally, the biopsy needle may penetrate the renal pelvis. This accident seems to be no problem and causes little difficulty.

Sampling Error

Many renal diseases tend to be patchy; hence a small sample may be uninformative or even misleading. Moreover, in one series,[2] 24 per cent of the punctures failed to produce any renal tissue. Kellow et al.[6] estimated the sampling error by comparing puncture specimens post mortem with ordinary histological preparations. Seventy-six per cent of their puncture specimens were representative of the histologic pattern of the kidney. Kark et al.[3] report, however, 93 per cent success in getting tissue, and 80 per cent success in having sufficient tissue for diagnosis.

Diagnostic Interpretation

Several problems immediately beset the diagnostic pathologist when he must express an opinion on a puncture biopsy. First is his incomplete knowledge of the details of the abnormal structure of the kidney in the early stages of many diseases. Our most complete knowledge of structure in renal disease is based upon studies done after the disease has proved fatal. In the diseases of shorter duration, we are much more familiar with the more severe forms than with the milder instances of the disease.

The size of the sample, even if it is representative, also presents problems. The diagnostic classification of a disease process is based upon a study of all factors. A knowledge of the sequence of clinical events and laboratory findings, coupled with fairly detailed gross and microscopic observations of all the organs, is necessary. Even under such circumstances, absolute classification may be difficult and, in rare instances, impossible. Hence, a small bit of tissue containing a few glomeruli, tubules, and vessels, coupled with incomplete clinical information, may be more confusing than helpful.

The study of Kellow et al.[6] throws some light on this problem. Their puncture specimens were interpreted solely on the basis of

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anatomic changes and the diagnoses on this basis were 69 per cent "correct." The "correct" diagnosis is presumably that made following complete study of the autopsy and clinical data. If the interpreter had had what clinical information was available, he probably could have done better. This study is, however, based on fatal cases; and, as mentioned above, interpretation may be easier than in the earlier stages of a disease.

The "diagnostic accuracy" in this study also varied with the disease. For example, the record was 81 per cent "correct" on vascular disease but only 31 per cent "correct" in pyclonephritis. Other reports point out that the diagnosis of acute glomerulonephritis is usually made readily on puncture specimens.[4] Similarly, acute tubular lesions, neoplastic involvement, certain specific infections, amyloidosis, the Kimmelstiel-Wilson lesion are often easily recognized. Occasionally, the first indication that a patient has amyloid disease may be a renal biopsy.[7] On the other hand, distinguishing certain varieties of glomerulonephritis from disseminated lupus erythematosus is said to be very difficult. The clinical evidence is often helpful, and there are reports that study with the electron microscope may be of considerable aid in this and other similar problems.[4]

As our knowledge of the early stages of many diseases increases, the diagnostic interpretation of puncture biopsies should improve. It may be that biopsy evidence could be more helpful than autopsy findings in the final classification of certain cases, particularly in making the distinction among late stages of chronic glomerulonephritis, chronic pyelonephritis, and nephrosclerosis.

There are, however, some practical reasons why a biopsy might be of value even if a definite diagnosis cannot be made. For example, Brun et al.[5] use the biopsy findings as an aid in deciding whether or not to use dialysis.

Pyelonephritis

This disease is of interest since it is at least in part treatable with modern therapeutic agents and surgical techniques. The clinical picture presented may at times be indistinguishable from chronic glomerulonephritis or from nephrosclerosis. Hence, a biopsy could be of considerable help. Unfortunately, this disease may be difficult to establish with only a needle biopsy. Kipnis et al.[8] studied a number of patients with chronic infections of the urinary tract. They found that, if renal function was depressed, a renal biopsy often showed anatomic changes; whereas, if the biopsy proved normal, frequently renal function tests were normal. These findings could mean that the kidneys were not infected in the latter group; but, more likely, it could mean that the disease was confined to areas that were not sampled. If there is a high probability of finding the lesions in a biopsy only after sufficient irreversible damage has been done to decrease renal function, the technique has little to offer in management.

Acute Tubular Lesions

Here we find that biopsy techniques in reality do little more than substantiate the more traditional concepts gained from studies at autopsy. The study of Siegeler and Malfetano[9] illustrates this very nicely. They biopsied a few patients with puerperal anuria and found tubular lesions, as autopsy studies would predict.

Toxemia of Pregnancy

Dieckmann et al.[10] obtained biopsies from 71 patients with eclampsia, pre-eclampsia, hypertension, and nephritis during pregnancy. In general, the eclamptic and pre-eclamptic patients had glomerular lesions similar to those traditionally associated with the disease—that is, a distinctive basement membrane thickening as observed in the light microscope. A somewhat surprising finding was that several patients thought to represent hypertension in pregnancy rather than pre-eclampsia had similar lesions. This raises several obvious questions about the validity of the diagnostic categories and the specificity of the lesion. The clinical and anatomical correlation in the few patients with chronic glomerulonephritis was very good.

Glomerulonephritis

Brun et al.[11] biopsied 13 cases in which a clinical diagnosis of acute glomerulonephritis was made. The biopsies showed a variety of patterns ranging from typical lesions of acute glomerulonephritis through lesions usually associated with chronic nephritis. They admit that some of these cases could have represented

an acute exacerbation of chronic nephritis. They feel that our concepts of the anatomical picture of acute glomerulonephritis need modification. Against their interpretation is the fact that only two children were included in the series. The two children both had typical lesions of classic acute glomerulonephritis, and one had a preceding tonsillitis. A pre-existing recent streptococcal infection was not clearly evident in many of the other cases. Another difficulty in evaluating such studies is the different criteria used (both clinically and anatomically) in distinguishing the "acute," "sub-acute" and "chronic" stages of the disease. Other studies of this disease, particularly with the electron microscope, have largely supplemented and confirmed knowledge gained earlier by means of the light microscope.

"Lipoid Nephrosis"

The exact nature of the renal lesion in this disease has long been a matter of dispute. Studies of renal biopsies by the electron microscope have apparently resolved this problem to some extent. For example, Farquhar, Vernier, and Good[12] first showed a consistent alteration in the epithelial cells of the glomerular tuft. This consists of a loss of the foot processes with a close application of the rather dense cytoplasm to the basement membrane.

Lupus Erythematosus Disseminated

Kark et al.[13] have studied biopsies from various stages of lupus erythematosus. From their experience, they have built up a schema of progressive glomerular changes as the disease evolves. What appear to be the earliest changes in lupus have been described by Farquhar et al.[12] Their studies with the electron microscope show early thickening of the basement membrane with subsequent appearance of "fibrinoid" material. Arnold and Spargo[4] claim that early lupus and early glomerulonephritis can be readily distinguished under the electron microscope.

Comment

Certainly, in the application of the electron microscope to renal disease, the percutaneous renal biopsy is a major advantage since it avoids the inevitable autolytic changes in autopsy material.

How useful the technique is in the management of renal disease depends largely on circumstances. There are many enthusiastic reports in the literature; but, before anyone embarks on a program of percutaneous renal biopsy, the cautious, well-reasoned papers of Ross[14] and Ross and Ross[15] should be carefully studied. They have made a careful and objective study of the usefulness of the technique. Their conclusion is that, as a research tool, the biopsy is very valuable; but, as an aid to management of patients, it has limited usefulness.

As in any medical technique, with good judgment and proper selection of cases, much can be learned; but indiscriminate use can do harm and waste time, effort, and money.

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The Edema Of Acute Glomerulonephritis

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ACUTE glomerulonephritis may be considered analogous,[1, 2] in many respects, to serum sickness. It involves antigen antibody reactions incited by infection with "nephritogenic" group A, B hemolytic streptococci. These mechanisms are discussed in detail elsewhere in this symposium.

Pathophysiology of Edema

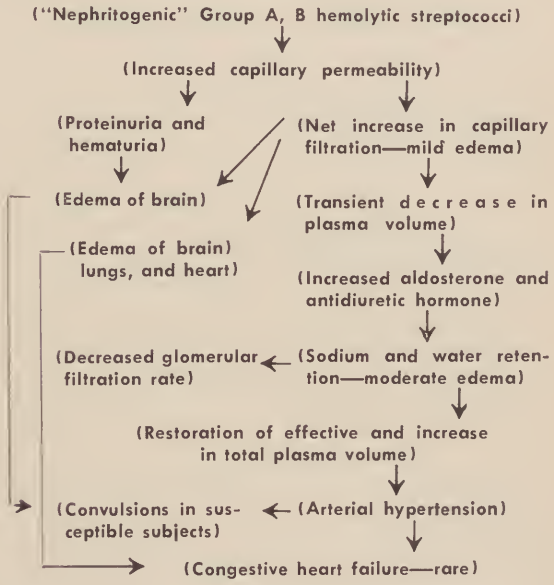
It has long been known that alterations of sodium and chloride excretion and of the internal distribution of water may occur in infectious disease and also in drug hypersensitivity. Aikawa and Harrell in 1951[3] investigated these disturbances and their relation to the development of humoral antibodies in experimentally-induced serum sickness in the rabbit. Clinical edema occurred with significant increase in weight and in the thiocyanate space. Concomitant decreases in plasma volume, total blood volume, and hematocrit were observed. They attributed these changes to increase in the permeability of capillary walls which resulted in loss of colloids, crystalloids, and red blood cells.

Subcutaneous edema may be the earliest[4] clinical evidence of acute glomerulonephritis. At the onset of the disease, it is generalized and is most apparent in the face and periorbital soft tissues. The degree of edema varies greatly from patient to patient and depends on the severity of the process and upon dietary intake of salt and water. Myocardium,[5, 6] brain, kidney, and lung may be involved to varying degrees.[7] Radiographically, in the latter, it can be observed to produce a characteristic ground-glass appearance located in the central portions of the lung fields unassociated with congestive heart failure.

Theories of Pathogenesis

The pathogenesis of the edema of acute glomerulonephritis involves certain controversial points. There are those who minimize the importance of the kidney and emphasize generalized capillary damage.[8, 9, 10, 11, 12] Others emphasize the role of glomerular filtration rate and excessive reabsorption of sodium and water.[13] It is probable that all of these factors are involved to some extent in all cases. There seems to be general agreement that the glomerular capillaries, at least, are invariably damaged.

In a monograph on edema edited by Moyer and Fuchs,[4] a diagrammatic schema is presented which illustrates some of the events and relationships in acute glomerulonephritis. This is presented in somewhat modified form:



Earle, Farber, Alexander, and Pellegrino,[13] in 1951, demonstrated the role of acute reduction of glomerular filtration and relatively normal tubular absorptive capacity for sodium in

the formation of edema. The role of aldosterone and antidiuretic hormone have been demonstrated subsequently.

The protein content of edema fluid in acute glomerulonephritis was formerly thought to be in the range of 1.0 gm. per 100 cc.[15, 16] More recent determinations by Stead and Warren[17] give values ranging from 0.4 to 0.8 gm. per 100 cc. Even these lower values are distinctly higher than those found in the edema of the nephrotic or the starvation syndrome. It is obvious that loss of albumin across injured capillary membranes will vary with the severity of the process and that its concentration in extracellular fluids will depend on the degree of dilution in the extracellular space.

It has been stated[15] that the plasma protein levels in acute glomerulonephritis are normal. It has been observed that, whereas plasma protein values are normal at the onset of the disease, frequent observations during the recovery phase show a concomitant increment in albumin as high as 1.5 gm. per 100 cc. This can probably be attributed to return of lost albumin via the lymphatics and the subsidence of hypervolemia. It would follow that an elevated albumin content of edema fluid, a low normal concentration of circulating albumin, and a decreased renal excretion of sodium and water should produce a situation which could favor the further accumulation of edema.

Treatment

The edema of acute glomerulonephritis subsides spontaneously in most cases in seven to ten days. In the last century, it was customary to treat it vigorously with diuretics, diaphoretics, and purges. It is interesting to note Delafield's departure from current opinion in 1894: "It (edema) disappears of itself as the nephritis subsides. The rest in bed and the hot pack are all the treatment necessary for it. To give diuretics or cathartics to get rid of the dropsy is quite useless." Today, complete bed rest and sodium restriction are the only measures customarily employed.

Summary

1. The edema of acute glomerulonephritis is a resultant of antigen antibody reactions in response to certain Group A streptococci which lead to injury of small blood vessels. This, in turn, interferes with renal excretion of sodium and water and decreased glomerular filtration rate.

2. Edema is generalized and is not necessarily associated with congestive heart failure.

3. There is no gross alteration of plasma proteins.

4. It subsides spontaneously without definitive treatment.

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The Physiological Foundation Of Diuretic Therapy†

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A DIURETIC agent is one which increases the rate of urine flow thereby decreasing the mass of body fluid. The main clinical indication for diuretic action is to reduce pathological accumulations of body fluids, most of which are extracellular in location. Such accumulation of fluids consists of two components—water and solute. The water component, accounting for the increase of body weight, causes the clinically observed swelling and pitting by reason of its extracellular location. The solute component (the same in chemical composition as that of extracellular fluid) is ionic in nature, consisting mainly of sodium and chloride ions plus a small amount of other extracellular ions.

The kidney maintains, at constant levels, the concentration in body fluid of the Na, Cl, and other solutes. Pathological losses or accumulations of body salt result in corresponding losses or accumulations of body water by spontaneous renal adjustments. Losses are manifested clinically in dehydration states (diarrhea, diabetes, Addison's Disease). Accumulations are manifested in edema states (cardiac failure, renal failure, cirrhosis with ascites, etc.). Most diuretic agents, used therapeutically to eliminate edema, operate by driving both salt and water from their extracellular reservoirs via the kidney to the urine. Diuretic agents may or may not operate upon the primary disease process, whence such therapy is usually symptomatic rather than specific in type.

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Classification of Diuretic Agents

The following is a brief survey of the mechanisms of action of some of the commonly used drug diuretics.

Prior to discussion of individual drugs, it is logical to categorize them within the framework of factors which increase the water and solute content of urine by virtue of direct action on the kidneys. Such a classification of diuretics is presented in Table I.

Table I

A. Osmotic or solute diuretics:
   1. Those which stimulate renal action by producing primarily a change in plasma composition.
      a) Nonelectrolytes:
         (i) Sugars—mannitol, sucrose, etc.
         (ii) Urea
         (iii) Creatinine
      b) Electrolytes:
         (i) Na^+ salts of NO_3^-, Cl^-, HCO_3^-, $SO_4^=$, $S_2O_3^=$, $Fe(CN_6)^=$, P.A.H., lactate, etc.
         (ii) K^+, H^+, and NH_4^+ salts of the same anions. Dose of these salts or acids is limited by the toxic effect of the cation—in particular, potassium.
   2. Those which stimulate renal action without inducing acute change in plasma composition, but which act primarily on the renal tubular cells.
      a) Mercurials
      b) Acetazolamide (Diamox)
      c) Chlorothiazide
      d) Antialdosterone
         (i) Amphenones*
         (ii) Spirolactones

B. Water Diuresis: Alcohol, Diabetes Insipidus, and Ingestion of Water.

C. Action on renal hemodynamics: Xanthines

*Amphenones don't act directly on tubule cells. See text under section on amphenones.

Comments on Table I: Osmotic or *solute diuresis* is due primarily to an excess of solute in the renal tubule. The excess solute could have arrived at a site in the tubular lumen by filtration of an excess solute load (after i.v. loading with solutes as classified in Table I

under A-1) or by failure of reabsorption of solute (occasioned by action of drugs as listed in Table I under A-2). Excessive solute in the tubule prevents reabsorption of water by virtue of its osmotic force acting across tubule walls, e.g., the water tends to move from the less concentrated solution, interstitial fluid, to the more concentrated solution, tubular lumen.

Water diuresis is due primarily to lack of action of antidiuretic hormone (vasopressin) upon water reabsorbing sites in the distal nephron and in collecting ducts. Since solute reabsorption continues, apparently unaffected by the hormone lack, urine in the tubule becomes diluted, but remains high in volume.

Mechanism of Action of Commonly Used Drug Diuretics Organic Mercurials

Inorganic salts of mercury, e.g., calomel, have been known for almost four centuries as diuretic agents. A potent diuretic action following injection of organic mercurial compounds (Novasurol) was discovered in 1920 by Saxl and Helig. The direct renal action of organic mercurials was established by Bartram in 1932[1]. Injection of a small dose into one renal artery induced diuresis from the homolateral but not from the contralateral kidney. This eliminated the theory of a "tissue" or extrarenal action of mercury which held that the drug, in some way, liberated salt from tissue binding sites.

Injection of mercurials into normal dogs or into men induces an increased flow of urine rich in sodium and chloride. Presumably, the drug gains access to renal tubular cells, wherein it complexes chemically with sulfhydryl groups of certain proteinenzymic systems. It is believed that free sulfhydryl groups are necessary for salt reabsorption. Consequently, their obliteration via mercury complexing (mercaptide formation) stops the process of salt reabsorption thereby leaving an excess of salt in the renal tubule. The excess salt, in turn, causes a failure of water reabsorption with consequent osmotic diuresis. One of us[2] has demonstrated that the urinary solute and water make-up after mercuhydrin given to hydropenic dogs was no different than that after any osmotic diuretic agent listed in Table I. This means that the action of mercury is unchanged during periods of maximum ADH activity. Conversely, Capps

Table II

Characteristics	Diuresis	
	Osmotic	Water
Osmotic or Solute Concentration	Osm. Conc. Urine greater than Osm. Conc. Plasma	Osm. Conc. Urine less than Osm. Conc. Plasma
Response to injection of ADH	No response to ADH. Action of hormone max. even at high urine flow	Sharp decrease in urine flow and increase of osmotic conc. of urine after ADH.
Response to injection of hypertonic solute	During osmotic diuresis, e.g., glycosuric diuresis, Urine flow increases because of extra solute load imposed on renal tubule.	In water diuresis, with intact ADH system, a transient decrease of urine flow. In diab. insipidus, no change or increase of urine flow (Hickey-Hare).
Response to neural stimuli	No effect on urine flow of painful stimuli.	Marked reduction of flow and increase of urine solute conc. after painful stimuli during water diuresis.

Osmotic Diuresis versus Water Diuresis

Comments on Table II: A broad view of some of the distinguishing features of both osmotic and water diuresis is shown in Table II.

The outstanding clinical example of osmotic diuresis is the glycosuric polyuria of untreated diabetes mellitus. Even though the urine flow is high, the total solute concentration (osmotic concentration) of urine *exceeds* that of plasma.

The outstanding clinical example of water diuresis is the polyuria of diabetes insipidus due to lack of antidiuretic hormone (ADH). Characteristically, the osmotic concentration of urine is always *less* than that of plasma. Excessive ingestion of water in normal subjects leads to a transient state identical to that of diabetes insipidus during the peak of urine flow. A complete discourse on the nature of "simple" water diuresis is beyond the scope of the present paper.

et al.[3] have shown that in overhydrated men and dogs response to ADH is the same whether the subjects were pretreated with mercury or not.

Potentiation and Suppression of Mercurial Action: After repeated administration of mercurial drugs, plasma chloride and sodium, but not bicarbonate, are removed from body fluids. The common clinical result is an alkalotic patient who does not respond to subsequent injections of organic mercurials. Conventionally, responsiveness may be restored by administration of NH_4Cl or HCl. In addition, administration of hypertonic NaCl, if deemed feasible, will restore responsiveness to mercurial therapy in some refractory patients.

"Diamox" (Acetazoleamide)

Pitts[4] noted that sulfanilamide reduced excretion of urinary acid while increasing that of sodium in dogs. Schwartz[5] reasoned that such effects would be useful in the treatment of congestive heart failure and was the first to use sulfonamide drugs for this purpose.

Ideas on mechanism of action of sulfonamides centered first on their ability to reduce secretion of hydrogen ions (or acid) by cells of the stomach and kidney. Carbon dioxide, the final product of metabolism, is produced by all cells. When formed, it reacts with water as follows:

$$CO_2+H_2O \rightleftharpoons H_2CO_3 \rightleftharpoons H^+ + HCO_3^-$$

Meldrum and Roughton had shown that the first part of the reaction (hydration) is catalyzed by an enzyme called carbonic anhydrase. Since carbonic anhydrase was found in the stomach and kidney, as well as in erythocytes, it was supposed to accelerate formation of hydrogen ions which, in turn, were secreted into gastric juice or into urine. Sulfonamides inhibited carbonic anhydrase activity *in vitro* and reduced acid secretion by both stomach and kidney in whole animals, including man.

"Diamox," or 2-acetylamino—1, 3, 4-thiadiazole—5-sulfonamide synthesized by Roblin and Clapp in 1950[6] was, and still is, the most potent *in vitro* inhibitor of carbonic anhydrase. Its effect on the in-situ kidney is to reduce urinary acidity and to increase urinary sodium, bicarbonate, and pH.

The drug, by blocking acid secretion, also blocks renal tubular reabsorption of bicarbonate ions. Consequently, an excessive amount of bicarbonate and sodium remain in the renal tubule. This, in turn, blocks reabsorption of water by virtue of an "osmotic pull" on water by retained tubular solutes. The effect is that of a typical osmotic diuresis with the final urine being increased in volume and higher in solute concentration than the plasma.[7]

The magnitude of Diamox diuresis is not so great as that of organic mercurial diuresis. Even though Diamox is the most potent *in vitro* inhibitor of carbonic anhydrase and produces changes in acid-base balance of both urine and plasma, it is a *weak diuretic.*

Failure of diuretic response to successive doses has been one of the main clinical disadvantages in therapy with Diamox. Doses have to be spaced at least one week apart if reproducible diuretic action is desired. The main advantage of Diamox, when used, is the fact that it can be given by mouth. Chronic and repeated administration may result in repeated losses of bicarbonate ion. This, in turn, acidifies body fluids. Another effect of Diamox administration is that of increasing potassium losses via the urine,[8] presumably by drug interference with a "coupling" of unspecified type between secretion of potassium and of acid in the renal tubule. Theoretically, excess potassium loss ought to be corrected by oral or parenteral administration of potassium, e.g., as potassium chloride.

Suppression of Diamox Action: Maren showed that systemic acidosis due to ammonium chloride administration reduced the renal effect of Diamox.[9] One of the present authors showed that acidosis of any type (metabolic, due to acid loading; or respiratory, due to CO_2 inhalation) would reduce the renal effect of Diamox.[7] Since repeated doses of Diamox can acidify body fluids, one would expect that the effect of each successive dose would be suppressed—an expectation confirmed by clinical observations in patients receiving Diamox.

Chlorothiazide

At first (1957), chlorothiazide was synthesized for the purpose of finding another *in*

vitro inhibitor of carbonic anhydrase which would act as an oral diuretic and which would become an effective economic competitor with Diamox. *In vitro,* chlorothiazide had but a fraction of the carbonic anhydrase inhibitory power of Diamox. However, when used in intact animals, it induced a far *more potent diuretic action than did Diamox.* This occurred despite the fact that its action on bicarbonate excretion was less than that of Diamox.

The urinary effect of chlorothiazide is as follows: After intravenous administration of doses of 10 mg./Kg., the rate of urine flow increases sharply to levels greater than those seen after Diamox but less than those seen after organic mercurials. The solute composition of urine after chlorothiazide is that of any osmotic or solute diuresis wherein the major solutes are similar to those in plasma. Thus such urine is rich in sodium, chloride, and bicarbonate. If the animal has been loaded with acid prior to the drug, the postchlorothiazide urine becomes increased in acid. If the animal has been loaded with alkali ($NaHCO_3$) prior to drug administration, the postchlorothiazide urine is increased in bicarbonate. In all cases, sodium is the predominant ionic constituent of urine during chlorothiazide diuresis.[10]

A postulated mechanism is that the drug blocks, specifically, reabsorption of sodium ion in the proximal tubule. This leaves an excess of sodium ion at a site in the renal tubular lumen. The sodium ion, by virtue of its positive charge, remains associated with *all* of the electronegative ions (chloride and bicarbonate, mainly) which had been filtered from plasma and had reached the proximal tubule at the site wherein drug-induced blockage of sodium ion occurs. The excess solute in the tubule results in the expected osmotic effect with solute diuresis.

Beyer has noted that repeated doses of chlorothiazide continue to induce diuresis successfully. He has attributed this to the direct renal action of chlorothiazide. Diamox, in contrast, is believed to enter erythrocytes and to remain therein for periods of three to four days. Beyer has related this fact of the observed refractoriness to successive doses of Diamox.[10]

Of clinical importance are recent observations on combined action of organic mercurial plus chlorothiazide.[11] In essence, the effect of adding chlorothiazide to a maximal dose of mercury was a purely additive increase in salt and water excretion. Apart from mechanistic implications, the therapeutic significance of such an experiment is obvious.

Recently, potent chemical analogues of chlorothiazide have been synthesized and used clinically. These include hydrochlorothiazide,[12] hydroflumethiazide,[13] and bendrofluazide.[14] All the analogues possess more diuretic potency than do equivalent amounts of chlorothiazide.

Antialdosterone Drugs

These agents have been the result of a pathophysiological approach to the treatment of edema. They inhibit the action of hormones in charge of controlling excretion of electrolytes, especially that of aldosterone. Aldosterone facilitates tubular reabsorption of sodium and chloride ions and increases excretion of potassium. Increase of aldosterone activity has been found under many instances of retention of water and electrolytes. The use of antialdosterone agents is indicated under such conditions.

Antialdosterone agents may be classified into two types: 1) *Amphenones,* which exert their action by inhibiting the formation of 11B-hydroxycorticosteroids directly in the adrenal gland; 2) *Antialdosterone steroids,* with a chemical structure similar to that of the salt-saving hormones, appear to act by a direct competition with the hormones for their sites of action on the renal tubule.

Amphenone: Amphenone, synthesized in 1950 by Allen and Corwin,[15] induced nonspecific endocrine effects as well as generalized depression of the adrenal cortex. Its toxicity limits its usefulness. Analogues were synthesized to obtain one of action limited to the adrenal cortex and, consequently, of low systemic toxicity. Allen and Bencze synthesized an amphenone analogue, SU 4885, which lowered adrenal vein corticoids content by 25 per cent to 100 per cent.[16] Jenkins et al.[17] found that large doses of SU 4885 would produce a generalized suppression of adrenal steroid synthesis followed by a period of selective suppression of 11-oxygenation blocking of formation of cortisol and aldosterone. Smaller doses produced inhibition of 11-oxygenation only.

By inhibiting 11-oxygenation, SU 4885 depresses formation of cortisol and of aldosterone. Since cortisol reduces ACTH secretion by the pituitary, SU 4885 results in an increased secretion of ACTH. This elevation of ACTH results in an increased formation of unoxygenated 11-desoxycorticoids including DOC. Therefore, formation of two mineralocorticoids is affected after giving SU 4885 as follows: aldosterone secretion is depressed and DOC formation is increased; depression of aldosterone secretion causes an increase of salt excretion; while enhancement of DOC secretion causes a *decrease* of salt excretion. If both actions operate in an algebraic manner,[18] the effect of amphenone on salt excretion may cancel out. Consequently, amphenones could have little or no value as diuretic agents.

Antialdosterone Steroids: Kagawa,[19] in adrenalectomized rats, and Liddle,[20] in men, published in 1957 the effect of an antialdosterone steroid, spirolactone, on salt excretion. Spirolactone, given to adrenalectomized rats treated with DOCA or aldosterone, caused an increased urinary excretion of sodium and a decreased excretion of potassium. Apparently, spirolactone blocks the action of both aldosterone and DOC in accordance with relative concentrations of inhibitor and of hormone perfusing the renal tubular cells.

In untreated adrenalectomized rats, spirolactone had no effect on sodium or potassium excretion, suggesting that the drug had no action on the nonhormonal component of tubular salt reabsorption.

Liddle used spirolactone in patients with edema due to cirrhosis, nephrosis, and congestive heart failure.[20] In general, the drug induced loss of edema fluid with associated natriuresis. In Addison's Disease, a saluretic response to spirolactone was obtained only if the patient had been pretreated with DOCA. In normal subjects, the increased salt excretion, induced by spirolactone, occurs only if subjects had been on low salt diets. Increased excretion of aldosterone was detected in urine of these patients. In short, spirolactone suppressed only aldosterone-stimulated salt reabsorption.

Spirolactone has been found useful in edematous patients refractory to Hydroflumethiazide (a chlorothiazide analogue) and to Mersalyl.[21] Such patients were afflicted with excessive salt retaining steroid activity which was reversed by spirolactone.

Alcohol Diuresis

Until recently, induction of water diuresis has not been used extensively in the treatment of edematous patients. This is because water ingestion often fails to induce diuresis at all (dehydrated subjects) or induces such a small increase in urine flow that the patient retains more water than he excretes. The latter effect (retention of water) has been explained by assuming secretion of excess ADH, even though the body fluids had been diluted.

In recent years, Van Dyke and his colleagues have found that alcohol could induce a true water diuresis in dogs.[22] Murdaugh has exploited this information successfully in the treatment of edema of certain types in human patients.[23] The main indications for alcohol diuresis were edema, hyponatremia, and good renal concentrating ability. The alcohol, given orally or intravenously (in doses equivalent to 100cc of absolute alcohol daily), would suppress secretion of ADH (Murdaugh). This, in turn, induced excretion of large volumes of urine, lower in solute concentration than plasma. As a result of excess urinary water loss, the patient lost edema water and body weight but retained salt. Thus, the alcohol also corrected the hyponatremia—a desired effect in such cases.

Summary

A classification of diuretic agents and a physiological distinction between osmotic diuresis and water diuresis have been presented.

The mechanism of action of some commonly used drug diuretics has been reviewed.

1) *Organic mercurials,* the most potent of drug diuretics, induce an osmotic diuresis by blocking tubular reabsorption of sodium chloride. Management of patients who fail to show a diuretic response to mercury has been discussed.

2) *"Diamox"* (Acetazoleamide), one of the first effective oral diuretics, induces a mild osmotic diuresis by blocking reabsorption of bicarbonate and of sodium ions. Diamox also induced a mild potassium diuresis, an effect which may be corrected during therapy with

the drug. Since refractoriness to Diamox action appears with the second successive dose, successful therapy is achieved by giving repeated doses after 5-7 day intervals. Acidosis, both metabolic and respiratory, will suppress the renal action of Diamox.

3) *Chlorothiazide* and its analogues are the most potent *orally* administered diuretic drugs. Although they are weaker *in vitro* inhibitors of carbonic anhydrase than Diamox, they exert more potent diuretic action *in vivo* than does Diamox. Chlorothiazide induces an osmotic diuresis by blocking tubular reabsorption of sodium, of chloride, and some bicarbonate ions under conditions of normal plasma composition.

4) *Antialdosterone Drugs:* (a) *Amphenones* block formation of aldosterone in the adrenal cortex and, secondarily, increase formation of adrenal DOC by stimulation of ACTH secretion from the anterior pituitary gland. Since each effect acts oppositely on salt excretion, amphenones are poor diuretics.

(b) *Spirolactones* compete with mineralocorticoid hormones for sites of action in the renal tubule. If they displace aldosterone from its occupation site, reabsorption of sodium and chloride will be blocked; and an osmotic diuresis will occur. Spirolactone therapy has been used in edematous patients with excessive amounts of aldosterone on the plasma. (Secondary hyperaldosteronism.)

5) *Alcohol-induced water diuresis.* Alcohol induces a water diuresis by a suppression of secretion of ADH from the posterior pituitary, i.e., by inducing a state of transient diabetes insipidus. Such a therapeutic effect is desired in an edematous patient with hypotonic (hyponatremic) body fluids and with good renal-concentrating ability.

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Renal Function In Hypertension and Its Relation To Antihypertensive Drug Therapy†

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THE exact part played by the kidneys in the pathogenesis of hypertension remains obscure. However, it is widely recognized that bilateral renal disease of diverse types often leads to hypertension, and in its turn primary hypertension often leads to renal abnormality. With the advent of means of therapeutically challenging both essential hypertension and hypertension secondary to renal disease, it becomes all the more essential that renal function in both treated and untreated hypertensive patients be well understood. The purpose of this article is to summarize current concepts of renal function in hypertensive patients.

Hemodynamic Factors in Renal Function

Virtually all blood flow to the renal parenchyma is via the afferent arteriole, glomerulus, and efferent arteriole. The state of the afferent and efferent arterioles, both functional and organic, is therefore crucial. The relation of pressure and flow in the renal arterioles is indicated by the following simple formula: Pressure = Flow × Resistance. It is obvious from the above relationship that since renal blood flow is not increased in hypertension (see below), resistance must be increased in the kidneys in hypertensive patients to at least a degree proportionate to the increase in pressure. Indeed, an overall increase in peripheral resistance is the basic hemodynamic abnormality in hypertension. As a corollary, any drop in blood pressure, whatever the cause, must result in a decrease in renal blood flow unless resistance in the renal arterioles also falls. It has been well demonstrated experimentally by means of pyrogens[1] that at least part of the increase in renal resistance in hypertension is functional and temporarily reversible. The whole rationale of drug therapy in humans is based on the ability of drugs to decrease functional renal vascular resistance while decreasing blood pressure.

Another hemodynamic factor which may be of importance in assessing renal blood flow in treated hypertensives is the "critical closing pressure." This latter may be defined as the critical level of pressure below which an elastic tissue containing blood vessels becomes unstable and closes with a cessation of flow despite a significant pressure within the lumen of the vessel.[2] The higher the resistance in a vessel, the higher the critical closing pressure. Thus, if blood pressure is decreased, especially if functional renal vascular resistance does not also fall, there is a risk of approaching the critical closing pressure with a subsequent cessation of blood flow in some renal arterioles.

Renal Function in Essential Hypertension

Early in the course of essential benign hypertension, glomerular filtration rate is normal but renal blood flow is decreased. This latter abnormality is probably due initially to functional efferent arteriolar constriction.[1] The efferent arteriolar constriction also results in increase in intraglomerular pressure and a consequent increase in filtration fraction. Another characteristic of renal function in hypertension is a decrease in total functioning tubular tissue and a relative ischemia of the available functioning tubular tissue.[3] These changes in essential hypertension are similar in each kidney.[4]

When the diastolic hypertension is marked, there is a greater decrease in renal blood flow and a decrease in glomerular filtration rate.[5] In malignant hypertension, the decrement in

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renal function is consistently more severe.

Of considerable interest and importance is the natural history of renal function in untreated hypertensive patients. Such information is now available for a group of patients with hypertension of varying severity. Moyer et al.,[5] studied renal function in untreated hypertensive patients initially and after a 2-5 year follow-up period. In those untreated patients who had a diastolic pressure of less than 130 mm. Hg, the only change in renal function after follow-up was a 25% decrease in renal blood flow. Untreated patients with a diastolic pressure over 130 mm. Hg showed a marked deterioration in renal function with a rise in average BUN from 28 to 91 mg. %, a drop in average glomerular filtration rate from 74 to 48 cc./min., and a fall in average renal blood flow from 648 to 395 cc./min. All patients in this study who died in uremia were untreated patients. No treated patients died in uremia during the time of follow-up.

In the untreated patients with malignant hypertension, there was a further severe decrease in renal function in all patients during a 10 month follow-up period.

The authors rightly emphasize that although renal function in untreated patients with diastolic pressure under 130 mm. Hg showed little change with time, it is impossible to predict when a hypertensive will enter an accelerated phase with a more marked decrease in renal function. A consideration of the effect of antihypertensive therapy on renal function follows.

The Effects of Antihypertensive Drugs on Renal Function

Aside from any specific effect that an antihypertensive drug may have on renal function, its major effect will be determined by whether or not renal resistance falls as blood pressure is reduced.

Initial reports had suggested that 1-hydrazinophthalazine (apresoline) might have a specific effect in increasing renal blood flow. However, subsequent studies have indicated that this effect is slight and transient. Vanderkolk et al.[6] found that while oral apresoline tended to increase renal blood flow initially, after 11-15 weeks of therapy the same oral dose had no effect on renal blood flow. Stein et al.[7] found that although 3 of 4 patients who had a normal renal blood flow had a rise in renal blood flow when given intravenous apresoline, 4 patients who had a low renal blood flow had no rise when given intravenous apresoline. Apresoline had no effect on glomerular filtration rate.[6, 7] In acute studies, intravenous hexamethonium was reported to cause a slight fall in glomerular filtration rate and renal blood flow in the majority of patients.[7]

Since renal failure, especially in severe and malignant hypertensives, is a dangerous consequence of continued high diastolic pressure, the effect of adequate control of blood pressure on renal function is of considerable importance. Moyer et al.,[8] studied the renal blood flow and glomerular filtration rate in a group of treated hypertensives before and 2-5 years after the inception of treatment. In treated patients with a diastolic pressure under 130 mm. Hg, renal function was similar before and after treatment. As noted above, untreated patients in this group had a 25% reduction in renal blood flow. Similarly treated patients with benign hypertension and a diastolic pressure greater than 130 mm. Hg had no change in renal function after treatment. However, untreated patients in this latter group had a marked deterioration of renal function during the follow-up period, many of them becoming uremic. This was also reflected in mortality rates. In patients with a GFR of 40-59 cc./min., the mortality rate was 20% in the treated group and 100% in the untreated group. In patients with a GFR under 40 cc./min., the mortality was 43% in adequately treated patients, and 100% in untreated patients.

The effects of treatment on renal function is equally startling in the malignant hypertensive group.[8] As in the other groups, while renal function did not improve under treatment, it nevertheless showed no further deterioration. On the contrary, renal function rapidly and severely declined in untreated patients with malignant hypertension. This can be well seen in a comparison of mortality rates. In untreated patients, all 9 patients were dead with an average survival period of 12 months. In treated patients, the mortality was 2 out of 12 after an average follow-up period of 29 months.[8]

A Clinical Approach to the Treatment of Hypertension

Considerable evidence has been presented that renal function may be impaired in hypertension, and in the untreated hypertensive may undergo further marked deterioration. This is especially clear-cut in the severe hypertensive and in the malignant hypertensive.

The goal of therapy of hypertension has recently been summarized as follows: 1) To reduce arterial pressure to normal or near normal levels in both supine and standing positions. 2) To control or prevent the consequences of arteriolar disease. 3) To prevent the advance of arteriosclerosis.[9] In terms of renal function antihypertensive therapy meets these aims, except in the advanced hypertensive with uremia. Unfortunately, uremia is common in the malignant hypertensive when first seen. In Kincaid-Smith's series of malignant hypertensives,[10] the blood urea was normal when the patient was first diagnosed in only 1 out of 21 patients with chronic glomerulonephritis, 10 of 43 patients with essential hypertension, and 5 of 25 patients with pyelonephritis. Perry et al.[11] found that only 1 of 20 patients with malignant hypertension and with an NPN over 61 mg. % (upper limit of normal in their laboratory 25 mg. %) survived despite treatment. According to Moyer,[12] in malignant hypertensives with NPN over 60 mg. %, the one year survival rate on drug therapy is zero.

Thus it would appear that from the standpoint of renal function, probably all hypertensives should be treated. Those in the malignant phase should be considered emergencies. When the NPN is over 60 mg. %, the prognosis is probably hopeless, though antihypertensive therapy should be tried. The level of blood urea or NPN is a sufficient indicator of renal function while the patient is under treatment. If the blood urea begins to rise this is an indication that the drop in pressure is causing a significant drop in renal blood flow and an indication that therapy must be halted or continued at a decreased dose. Often it is necessary to maintain a patient with a mild hypertension in order to prevent uremia. In some patients when blood pressure is reduced there is a temporary rise in blood urea which falls to pretreatment level in a few days despite maintenance of blood pressure reduction.[13] Many patients with hypertension develop a rise in blood urea because of dehydration and heart failure. Rigorous treatment of these complications should be carried out before it is concluded that a hypertensive is hopelessly uremic. One is often rewarded in such cases by a return of blood urea to normal or near normal levels. The following cases are presented to illustrate some of the problems discussed above.

Case I

This is a 36-year-old white male who developed glomerulonephritis while in the service in 1952. He had first been seen in the Veteran's Administration Hospital in 1953 when a diagnosis of nephrotic phase of chronic glomerulonephritis was made on the basis of albuminuria, hypoalbuminemia, and hypercholesterolemia as high as 1250 mg. %. In November of 1955, he began noting loss of vision in the left eye, two weeks later severe headaches and nausea occurred, and on 12/5/55, he was readmitted to the Veteran's Hospital. On admission, his blood pressure was 250/150. The eye grounds showed hemorrhages, exudates, and papilledema. Urinalysis revealed 4+ albuminuria, 10-12 RBC's/HPF, waxy and hyaline casts. PSP tests revealed only 10% excretion in two hours. Serum cholesterol was 410 mg. %, and NPN varied from 38-48 mg. %. Because the patient had underlying renal disease, it was decided not to treat his hypertension and he was sent on leave. While at home, he suddenly became blind and had a grand mal seizure. On readmission, he had weakness of his left arm and leg which slowly cleared with complete return of function. It was then decided to treat the patient's hypertension. His course until the present is illustrated in Fig. 1. All blood pressure readings are in the standing position. As will be noted, the patient has been kept at mildly hypertensive levels. This has been necessary because his NPN increased soon after therapy and has remained moderately elevated since then.

Comment

This case is of considerable interest. The initial decision not to treat the patient was in error. The presence of underlying renal disease does not contraindicate therapy.[9] The only important factor is the status of renal function.

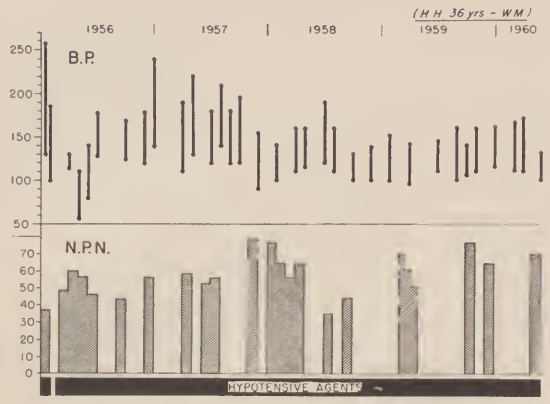


FIGURE 1: 36-year-old white male originally with malignant hypertension followed for 4 years.

This patient presents an example of 4½ years survival of a malignant hypertensive. Eye grounds now show only arterio-venous nicking. The patient is asymptomatic and works steadily. Despite a high NPN, he has been satisfactorily controlled.

Case 2

LGH#45068—This patient is a 49-year-old colored male admitted to the Louisville General Hospital on 4/8/60 with a three week history of ankle edema. He had been a known diabetic for 10 years and a hypertensive for 12 years. On admission, the blood pressure was 240/138. The eye grounds showed arterio-venous nicking, hemorrhages, and exudates. There was evidence of right heart failure. The blood urea nitrogen on admission was 16 mg.% (normal 10-15 mg.%). Urinalysis was negative.

He was started on antihypertensive therapy soon after admission. The results are shown in Fig. 2. All blood pressure readings are in the standing position. After 11 days of therapy, he developed marked orthostatic hypotension, with virtually no blood pressure recordable in the standing position. The blood urea nitrogen at this time rose to 92 mg.%. Therapy was discontinued with a drop in BUN. He was then maintained mildly hypertensive with BUN levels around 39 mg.%.

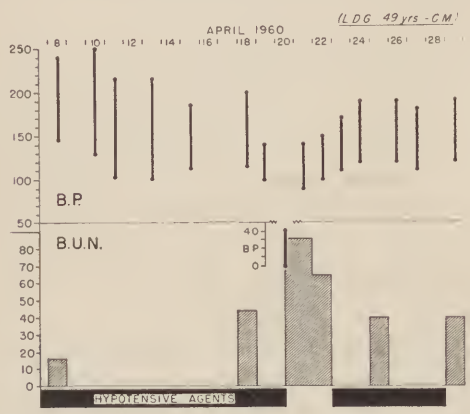


FIGURE 2: 49-year-old colored male with benign hypertension who developed uremia when treated with antihypertensive drugs.

Comment

The importance of gauging blood pressure response by standing readings is emphasized in this case. In this patient there probably will have to be a compromise between his hypertension and the height of blood urea.

Case 3

LGH#25603—This was a 56-year-old colored male, a known hypertensive, who had had shortness of breath for four months prior to his admission to the Louisville General Hospital on 3/26/60. He previously had been in the hospital during January of 1959, at which time attempts at lowering his blood pressure had resulted in a rise of blood urea nitrogen from 58 to 81 mg.%. He had been discharged only on serpasil. At the time of his readmission on 3/26/60, his blood pressure was 200/130. The eye grounds showed arterio-venous nicking, hemorrhages, and exudates. The BUN was 90 mg.%. His course from the time of his first admission to the Louisville General Hospital in January, 1960, is shown in Figure 3. All blood pressures are in the standing position. Antihypertensive therapy until the end of March consisted only of serpasil. Starting the end of

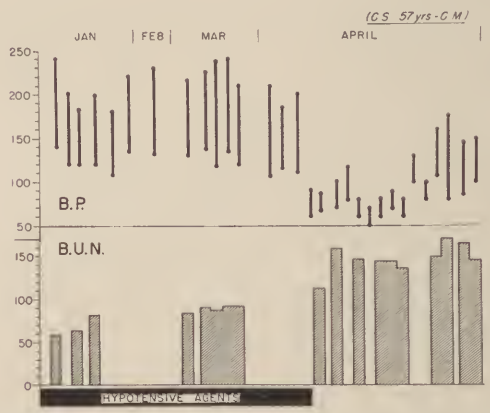


FIGURE 3: 57-year-old colored male with far advanced and untreatable hypertension.

March, Diuril and a ganglionic blocking agent were also given. Note that despite advanced hypertensive disease, this patient had a marked response to therapy. However, the drop in blood pressure was accompanied by a sharp rise in blood urea. Despite discontinuation of therapy, blood urea remained high.

Comment

This patient presents an example of far advanced untreatable hypertensive disease.

Summary

Current knowledge of renal function in hypertension has been presented. The deterioration of renal function in untreated hypertensives has been emphasized. Evidence has been presented that antihypertensive drugs may prevent further decrease in renal function in the hypertensive patient.

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Manuscript Memos

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In submitting a manuscript, the author is requested to include a concise summary, not to exceed 35 words, to be used as a sub-title when the article is published in The Journal. The purpose of the summary is to create additional interest and encourage greater readership.

Footnotes and bibliographies should conform to the style of the Quarterly Cumulative Index Medicus published by the American Medical Association. This requires in the order given: name of author, title of article, name of periodical, with volume, page, month—day of month if weekly—and year. The Journal of the KSMA does not assume responsibility for the accuracy of references used with scientific articles.

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Please mail your scientific articles to The Journal of the Kentucky State Medical Association, 1169 Eastern Parkway, Louisville 17, Kentucky.

Nephrocalcinosis

William W. Winternitz, M.D.*

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Introduction

NEPHROCALCINOSIS may be defined as the deposition of calcium salts within the renal parenchyma, the heaviest concentration of calcium being localized along the collecting ducts and thin segments and therefore in the renal medulla. This is in contrast to the calcification that may follow various renal injuries (such as Hg^{++} poisoning) in which the calcium is laid down at the site of injury and is therefore frequently more prominent in the renal cortex. In severe nephrocalcinosis, however, the entire renal structure, including the glomeruli, may become calcified.

The primary injury of nephrocalcinosis has been experimentally demonstrated to consist of renal tubular damage followed by calcification.[1, 2] Furthermore, it is well known that physiological disturbances (with or without microscopic calcification) may precede, for some time, the development of calcium deposition detectable by x-ray. The earliest and most characteristic alteration in function is the loss of concentrating ability[2, 3, 4] which results in polyuria and polydipsia. These symptoms are frequently the presenting complaints with this syndrome.

In acute cases associated with severe hypercalcemia there may be rapidly advancing renal failure.[5] In slowly developing chronic cases calcification may progress to an extreme degree with minimal symptoms (usually polyuria). In such cases one sees the typical x-ray picture of stippled or linear calcification scattered throughout the renal pyramids. (Fig. 1)

Prevalence

This lesion is not a common one. Its incidence is most difficult to define. Some idea of its occurrance rate may be gained from the Mayo Clinic experience.[6] Roentgenographically demonstrable renal calcinosis was seen in about 1 in 20,000 clinic registrants and in about 1 in 3,000 autopsies. Nephrolithiasis was about 200 times more frequent in this clinic population. The incidence will increase considerably if "nephrocalcinosis" is enlarged to include all patients with disturbances of renal function due to hypercalcemia and/or hypercalciuria, which would eventually lead to x-ray visible lesions if death or recovery did not intervene. The syndrome will be more unified pathogenetically



Bilateral stippled renal calcification.

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if the functional and early histological changes are included as well as the long term accumulation of gross deposits of calcium salts in the renal parenchyma.

Causes and Types of Nephrocalcinosis

The causes of nephrocalcinosis are not fully known. In nephrolithiasis about 1/3 of the individuals have hypercalciuria.[7] Other factors are responsible for the other 2/3. In nephrocalcinosis an unknown but larger percentage of cases have hypercalciuria[6, 8] and many have hypercalcemia. Conditions associated with excessive calcium absorption from the gut or excessive bone dissolution may lead to hypercalciuria, with or without elevation of the serum Ca^{++}, and precipitation of calcium salts may occur in the renal medulla. In some other cases, however, no increase of calcium in the blood or urine has been observed.[6, 8] Some of the more frequently encountered causes of nephrocalcinosis are listed in Table I.

TABLE I

Causes of Nephrocalcinosis

1) Hyperparathyroidism
2) Renal tubular acidosis
3) Osteolytic tumors
4) Sarcoidosis
5) Milk-alkali syndrome
6) Vitamin-D intoxication
7) Immobilization, and
8) Other causes, rarely

Hyperparathyroidism is perhaps the most frequent cause of nephrocalcinosis,[6] due presumably to the hypercalcemia and increased urinary calcium usually present. The second most common cause is the congenital defect known as renal tubular acidosis. This is characterized by systemic acidosis with alkaline or neutral urine and the inability to lower urinary pH to a normal degree following an acid load. A variety of other clinical conditions are known to result in nephrocalcinosis; they include widespread osteolytic tumors,[9, 10] immobilization,[11] vitamin-D intoxication,[12] sarcoidosis,[3] etc. The apparent common denominator of these illnesses is hypercalciuria with or without hypercalcemia.

There remains the group of patients in whom none of these conditions appears to be present and who do not show elevation of the calcium concentration of the blood or urine.[6] In this regard Wrong and Davies[8] made the interesting discovery that certain nephrocalcinotics *without* acidosis showed less than normal H^+ excretion following an acid load. These persons presumably suffer from a congenital renal tubular defect that is responsible for their calcinosis despite the fact that they have no extracellular acidosis and *no* hypercalciuria. The authors postulate that this is an incomplete or early form of renal tubular acidosis in which the lack of H^+ excretion is compensated by increased ammonium excretion. They attribute calcium deposition to some other associated defect and suppose that the calcification results in renal damage which diminishes ammonium production and allows acidosis to supervene. The early or incomplete defect can only be detected by maneuvers such as the acid loading test described by Wrong and Davies.[8]

Pathogenesis—Experimental Aspects

The precise pathogenesis of nephrocalcinosis is unknown, but certain relevant facts are of interest. Several experimental methods have been used to produce the lesions in animals. High calcium diets result in renal calcification in rats.[13] This may be analogous to the disease mechanism in sarcoidosis and idiopathic hypercalciuria where over-absorption of calcium is believed to be responsible for the hypercalciuria with or without hypercalcemia.[14, 15] Alkaline ash diets may intensify the process, as might be expected since calcium salts tend to be insoluble in alkaline solutions.[16] This is, of course, the mechanism that is believed to result in the calcinosis of the "milk-alkali" syndrome following prolonged treatment of peptic ulcers with milk and absorbable alkali.[17]

Certain chemicals unite with Ca^{++} to form chelates which are soluble compounds. One of these chelating agents is citrate, a substance which increases in normal urine as the pH increases.[8] In the rat acetazolamide administration greatly reduces urinary citrate and also results in nephrocalcinosis.[18] In this regard it is of great interest that urinary citrate has been found to be decreased in patients with renal tubular acidosis.[8, 19] This may explain the calcification that occurs in the incomplete form of renal tubular acidosis described above.

Nephrocalcinosis may be easily produced in animals by the administration of large doses of parathyroid extract or vitamin-D in a manner

analogous to that seen in human disease. Recent studies by Epstein and co-workers have contributed greatly to the understanding of the effects of calcium on the kidney. They re-confirmed the observation that elevation of the blood calcium by vitamin-D or parathyroid hormone rapidly results in decreased ability to concentrate urine and to excrete H^+. They then studied the effects of hypercalcemia of short duration on the kidney using tests of function as well as histological preparations of teased out individual nephrons. Functional changes lasted as long as two months following hypercalcemia of 24 hours duration. The nephrons showed necrotic changes in the epithelium, most pronounced in the collecting ducts. Calcium deposition occurred in these areas of damaged epithelium, first in the cells or in the lumen, later interstitially as new epithelium appeared to grow over the old. This provides further understanding of the toxic action of calcium which first damages tubular cells and then precipitates out with progressive damage to renal tissue and function.

Clinical Implications

The symptoms of nephrocalcinosis are often surprisingly few when compared to the striking x-ray appearance. Polyuria due to decreased concentrating ability is often a prominent symptom. The other effects are those relating to renal failure (in advanced cases) or to renal lithiasis which may co-exist with calcinosis. On the other hand, when the disease is acute with severe hypercalcemia there may be overwhelming symptoms and renal failure progressing to a fatal outcome in a matter of days.[5]

Nephrocalcinosis, although not common, is an important entity in that it can often be treated specifically and reversed to a greater or less extent depending on the stage of advancement. When nephrocalcinosis is demonstrated or suspected certain diagnostic possibilities must be established or eliminated as promptly as possible. Some of the characteristics of these disorders are listed in Table II, along with the therapeutic approach.

Summary

High concentrations of calcium in the blood or urine, sometimes combined with a deficiency of chelating agents (such as citrate) or with excess alkali, lead to renal tubular damage. Functionally, loss of concentrating ability is prominent. Histologically there is tubular necrosis, especially in the renal medulla, eventually leading to calcification in these same areas and further renal damage. In many cases the cause can be identified and rational treatment may lead to arrest or reversal of the disease process.

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TABLE II

Disorder	Diagnostic Characteristics	Treatment
Hyperparathyroidism	High serum Ca++, low Po_4=, phosphatase normal or increased	Parathyroidectomy
Renal tubular acidosis	Extracellular acidosis, neutral or alkaline urine, inadequate response to acid load	Alkali therapy
Sarcoidosis	High serum Ca++, normal Po_4=, other characteristics of sarcoid	Corticosteroid, low calcium diet
Milk-alkali snydrome	Normal Ca++, history of milk and alkali intake	Stop alkali, low calcium diet
Vitamin-D intoxication	High Ca++, history of vitamin-D therapy	Stop vitamin-D, low calcium diet
Idiopathic hypercalciuria	Normal serum calcium, high urine calcium	Na phytate orally, low calcium diet
Immobilization	Normal or high Ca++, extensive paralysis or immobilization	Mobilize, low calcium diet, Na phytate

A General Consideration of Pyelonephritis; Recent Advances

ARTHUR WHITE, M.D.*

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Introduction

INFECTIONS of the urinary tract are second only to infections of the respiratory tract among the infectious diseases of man. In addition to the disability associated with the symptoms of infection, pyelonephritis is also one of the most common causes of uremia and is the most common renal lesion found at autopsy—approximately 20 per cent of all autopsies at large general hospitals reveal pathological evidence of pyelonephritis. In approximately one-third of the cases of pyelonephritis found at autopsy, the lesion was the major cause of death; but pyelonephritis was suspected before death in only 20 to 30 per cent of the patients with pathological evidence of this lesion.[1] The diagnosis is often missed because the disease may be relatively asymptomatic for long periods of time or may not be accompanied by localizing clinical symptoms of pyelonephritis.

Despite the frequency with which pyelonephritis occurs, antibiotics have been disappointing in the treatment of many patients, particularly those with chronic pyelonephritis. Kass[2] has estimated that infection can be eradicated from only 10 per cent of patients with chronic pyelonephritis although approximately 90 per cent of cases with acute pyelonephritis can be cured. On the basis of these figures, our best hope of preventing the frequent occurence of pyelonephritis as a cause of death is the early detection and adequate treatment of patients with pyelonephritis during the acute or early asymptomatic stage before structural abnormalities or resistant organisms occur.

Quantitative Cultures

One of the most useful methods for the evaluation of pyelonephritis and urine cultures has been the introduction of quantitative cultures. The presence of bacteria in numbers greater than 100,000 organisms per milliliter usually indicates active multiplication of bacteria within the urinary system; counts less than 100,000 per milliliter usually represent contamination of the specimen during the process of collection. Quantitative cultures are not generally available, but a simple Gram's stain of freshly voided uncentrifuged urine will help differentiate infection from contamination since organisms are readily seen in urine samples containing more than 100,000 bacteria per milliliter but cannot be seen easily in urines containing smaller numbers of bacteria. Therefore, the presence of bacteria on a Gram's stain is indicative of true bacteriuria and not contamination.

In interpreting the results of quantitative cultures of urine or the examination by Gram's stain, the following factors must be considered:[2]

1) Urine must be carefully collected and either examined freshly or immediately refrigerated since bacterial growth can occur rapidly at normal room temperature.

2) If a bacteriostatic agent is present in the urine, bacterial counts may fall below 100,000 per milliliter in the presence of active pyelonephritis. Such a situation is encountered in patients who are receiving antimicrobial drugs.

3) If urine flow is rapid, bacterial counts may be below 100,000; and, for this reason, the first morning specimen is preferable to random specimens since bacterial growth will have had an opportunity to occur in the bladder.

4) A few fastidious organisms, such as Group A streptococci and anaerobic streptococci, grow poorly in urine and may be present in small numbers in infected urine. These bacteria are rarely responsible for urinary tract

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infections.

5) If the infected kidney is completely obstructed, bladder urines may be free of bacteria despite active pyelonephritis.

6) In urines with a pH below 5 and in very dilute urines with specific gravities below 1.003, bacterial multiplication may be inhibited. Under these circumstances, bacteriuria may be present in numbers less than 100,000 per milliliter in infected urine.

Provided these precautions are observed, true bacteriuria may be detected and differentiated from contaminated urine in clean voided specimens from either males or females.[3] Since catherization of the bladder is one of the major methods by which bacteria are introduced into the urinary tract, catherization for cultures is unnecessary and contraindicated in most patients.

Realtionship Between Bacteriuria and Urinary Tract Infections

The exact relationship between bacteriuria and pathological evidence of urinary tract infection has not been completely established. Only 50 per cent of patients with significant bacteriuria have pyuria; and, therefore, large numbers of bacteria can be present within the urinary tract without the usual laboratory evidence of inflammation. Although active pyelonephritis confirmed at autopsy is almost always accompanied by bacterial counts of greater than 100,000 per milliliter, many instances have been reported of significant bacteriuria with no morphological evidence of bacterial invasion of the kidney or bladder. However, asymptomatic bacteriuria occurs most frequently in patients who also have an increased frequency of pyelonephritis such as patients with obstructive uropathy, those with a past history of instrumentation of the G-U tract, and patients during pregnancy.

Recently, Kass[4] has shown that significant bacteriuria is present in 6 to 7 per cent of pregnant women and that clinical pyelonephritis develops in 40 per cent of the patients with bacteria in the urine usually several months after the initial detection of bacteria. In patients in whom bacteriuria was eradicated by treatment, clinical pyelonephritis did not develop.

Observations of this nature suggest that the detection of bacteria in the urine may be important in both the prevention of clinical infections and in the detection of disease before severe kidney damage has occurred.

Newer Antimicrobial Drugs

One of the possible disadvantages of the most frequently used antibiotics in the treatment of urinary tract infections has been the limited bactericidal action of tetracycline, chloramphenicol, and sulfa drugs. These agents are effective largely by preventing the growth of bacteria. The bactericidal agents which were available, streptomycin and nitrofurantoin, had other disadvantages. Streptomycin is bactericidal and present in large quantities in both blood and urine. However, bacteria develop resistance to streptomycin very rapidly. Nitrofurantoin (Furadantin®) is present in detectable quantities only in the urine and, therefore, might not be present in the renal tissues. Although it has not been proven that both tissue and urine levels of drugs were necessary for the treatment of urinary tract infections, many authorities have believed that, for the eradication of infection in the renal parenchyma, a drug which was present in high levels in both sites was necessary.

Two new drugs have been introduced which are effective against gram-negative bacteria and have been reported to be effective in the treatment of gram-negative infections, including urinary tract infections. Both of these drugs, kanamycin and Altafur®, are predominently bactericidal and give adequate blood and urine levels when administered in the proper doses. Also, the development of resistance to these drugs during treatment is very infrequent or has not been reported.

Kanamycin has the major toxicity of impairment of the eighth nerve with deafness development occurring during prolonged or excessive treatment. This is most likely to occur in patients with renal impairment since the drug is excreted predominently in the urine, and very high blood levels may develop in patients with impaired excretory function.

Altafur® is the first nitrofurantoin which gives adequate blood and tissue levels after oral administration. The major toxicity of this compound is the frequency with which nausea and vomiting is encountered after large doses

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EDITORIALS

Renal Physiology and Renal Disease: A Necessary Bedside Correlation

UNFORTUNATELY many clinicians still think of kidney disease as a hopcless jumble of diagnostic categories, clinically and histologically difficult to distinguish and physiologically too complex to have practical implications at the bedside. This conception is usually accompanied by a feeling of therapeutic futility. Such a combination of attitudes is dangerous for the patient and it dulls the physician's enthusiasm for discriminating action.

But more importantly, it is a position which is becoming increasingly more untenable. While the advances of the last decade in our knowledge of renal diseases have not had as dramatic effect as those in some other fields, there has nonetheless been an unprecedented increase in our understanding of the interrelations of the structure and function of the normal and diseased nephron. We are still far from comprehending precisely how this ingenious organ performs even its simpler excretory and regulatory functions, but much of what has been learned has great promise for the prevention and management of a growing number of renal disorders. In few clinical situations is the need to correlate recent physiological knowledge with the clinical management of the patient so urgent.

It would be impossible in a symposium issue many times the size of this one to review all the advances of importance occurring in the last ten years. We have selected a few topics with definite practical implications for specialists and general practitioners alike. There are in addition a number of physiological and investigative advances not covered in this issue which are worthy of brief editorial comment as further illustrations of the wide scope of new knowledge and the direction which investigations are taking in the near future.

The immediate postwar period in the investigation of the kidney was marked by the application of the clearance methods of Homer W. Smith[1] to a variety of clinical situations, renal and extra-renal. As a result, the varying patterns of glomerular and tubular functional disturbance were recognized in glomerulonephritis, the nephrotic syndrome, hypertension, congestive heart failure and acute tubular necrosis. The common occurrence of aberrations of renal hemodynamics in the presence of circulatory failure, water and electrolyte imbalance and many other acute illnesses became apparent. treatment of extra-renal factors in renal and This information has served to improve the treatment of extra-renal factors in renal and non-renal disease, especially from the viewpoint of more intelligent management of water and electrolyte balance.

Further refinement of clearance techniques and the application of a large number of new methods of studying the kidney in man and animals has extended our knowledge greatly in the last ten years. Electron microscopy has demonstrated the amazingly complex structure of the glomerulus and tubule and revealed the nature of the glomerular lesion in the nephrotic syndrome. Percutaneous renal biopsy, commented upon by Doctor Stewart in this issue, has served as a useful tool in the correlation of structure, function, and the natural history of renal disease. Study of the clearance of radioiodinated compounds by clinical isotope screen-

ing has added a powerful tool for the investigation and detection of unilateral renal disease in hypertension. The feasibility of aortography and renal angiography as a means of revealing the renal vascular abnormalities underlying some forms of hypertension, has been demonstrated. Of more fundamental importance to a better comprehension of the physico-chemical foundations of the kidney's activities are the use of in vitro metabolic studies on kidney slices and subcellular particles. Questions relating to the mechanism of dye secretion, inorganic ion transport, the actions of drugs, hormones and vitamins are being approached in this way. The metabolic role of the kidney in metabolism of ammonia, citrate and its possible role in the production of an erythropoietic agent are under active investigation. Histochemical studies have been useful in localizing within the nephron certain of the enzymes responsible for the metabolic activities of the kidney.

The revival of the technique of micropuncture of the tubule, first used so fruitfully by A. N. Richards and his coworkers in the Twenties, has contributed to the elucidation of a new view of the urinary concentration process.[2] In 1951 Wirz, Hargitay and Kuhn[3] suggested that the loop of Henle, by virtue of its hairpin arrangement, could function as a counter current multiplier. An increasing number of studies have provided detailed explanation of how the kidney can achieve urinary concentrations well above those of the plasma. No attempt will be made here to give an account of the workings of this mechanism except to mention the resultant events. As a result of the transfer of sodium from the ascending to the descending limbs of the loop of Henle, the urine undergoes increasing osmolarity as it descends into the medulla and decreasing osmolarity as it ascends to the distal tubule. At no point must sodium be transported against a large concentration gradient, yet as much as a fourfold gradient can be achieved between the cortex and the medulla. The osmotic work performed can be kept at a minimum. It is not yet clear whether significant alterations in this system could occur in disease but theoretically disease of the renal medulla or alterations in sodium or urea concentrations could produce profound changes in this vital renal function. The details of the counter current idea are not fully worked out and such questions as the role of urea and whether or not transfer of sodium into the descending limb is active or passive are under active investigation.

Equally noteworthy and of importance in understanding many normal and abnormal functions of the kidney is the phenomenon of ion exchange. Pitts and Alexander[4] in 1945 showed that more hydrogen ion is excreted in the urine than can be accounted for by glomerular filtration and they postulated that hydrogen ion must therefore be added to the urine by the tubule cells. Since then Pitts and others have accumulated evidence that the exchange of hydrogen ion in tubule cells for sodium in tubule urine is an essential mechanism in the excretion of titratable acid. The control of acid base balance is dependent upon the distal tubular secretion of hydrogen ion, upon the exchange of hydrogen for sodium ion in the reabsorption of bicarbonate and on the buffering of hydrogen ion by ammonia.[5] Berliner and his colleagues[6] have shown that potassium also participates in the exchange process with sodium ion in the distal nephron. This exchange is now known to be important in the regulation of acid base balance and in the balance of potassium in the cells and extracellular fluids. The practical implications of these ion exchanges in understanding the actions and side effects of the newer diuretics and in the management of acid base balance and potassium balance have been emphasized in numerous reports.

Kidney diseases have benefitted by the recent resurgence of interest in the genetic background of metabolic disorders. Much new information is now available on the congenital and acquired aminoacidurias as a result of the application of urinary amino acid chromatography to the study of cystinuria, galactosemia, the Fanconi syndrome and certain cases of resistant rickets.[7] Other renal tubular reabsorptive abnormalities, alone or in combination, are being described for phosphate, sodium, potassium, glucose and water. In a few instances the patterns are so specific that a single enzyme defect can be postulated in the renal tubule. The demonstration by Darmady [8] in cases of the Fanconi Lignac syndrome of a congenital deformity of the proximal tubule raises the possibility that other structural abnormalities may be found in the tubular dysfunctional syndromes. In others the complexity of reabsorptive disturbances is too great for such a ready explanation.

Even in cursory comments like these there

are a myriad of things which can only be enumerated but which represent areas of new information, important in kidney physiology—the localization and mode of action of hormones like the antidiuretic, parathyroid and aldosterone hormones; the mode of action of vitamins A and D on the kidney; the therapeutic effectiveness of ACTH and the adrenal steroids in the nephrotic syndrome; the mode of renal action of the digitalis glycosides, the pathogenesis of pyelonephritis and many others.

I have merely outlined some of the important advances being made in our knowledge of the normal and diseased kidney in very recent years. The promises for the future are great. It is abundantly clear that the application of this knowledge to the care of patients with renal disease is an increasing necessity and a responsibility. Complex though some of these physiologic phenomena may be, they are assuming a practical importance for clinicians in all branches of medical practice.

Integration of clinical and basic physiologic data in all phases of medical education has become a byword for the medical educator. As the papers in this issue indicate and as the field of renal physiology demands, integration is equally urgent at the bedside.

E. D. Pellegrino, M.D.

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Denver Winter Meeting Offers Excellent Scientific Program

THE 15th annual American Medical Association clinical meeting in Denver Nov. 26-30 will offer a combination of fundamental post graduate knowledge plus the latest findings in a number of areas of medical research that will be of great benefit to all of us in the conduct of our practice.

As a former member for many years of the Council on Scientific Assembly, I have followed the progress and development of the winter clinical meeting from its inception. I can state without qualification that the program organized for this 1961 Denver meeting is the best that has ever been assembled.

At the annual meeting in New York last June, the Board of Trustees and the House of Delegates once again put their stamp of approval on the winter clinical meeting as a vital part of the American Medical Association's service to its membership to provide continuing education and knowledge.

It is my personal hope and appeal that every member of the American Medical Association will take full advantage of the opportunities offered at the Denver meeting by attending all five days.

There are many highlights in the clinical programs that will be of value and interest to the clinician.

All of us in practice are well aware that the personal habits of our patients, plus the habits of the social group of which they are a part, play a major role in health.

This phase of medicine has been studied in detail by a group of Colorado physicians, and they will present their findings in a series of papers at the Denver meeting.

Space medicine is very much in the news these days. Many of us are only vaguely aware that the research specialists in space medicine also are learning much that will be of value to the physician in everyday practice. Several specialists in space medicine will present papers analyzing some of these findings.

Every physician knows that heredity is important in tracing the patient's pattern of disease. The research scientists are now learning much more about this important aspect of medicine, and a section on genes and chromosomes

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ORGANIZATION SECTION

KSMA Members Urged To Take Part in Diabetes Drive

All KSMA members are urged to participate in the annual Diabetes Detection and Education Drive. It is being sponsored again this year by the KSMA in cooperation with the American Diabetes Association and will be held the week of November 12-18.

Of the counties that have indicated they will participate, approximately 30 still have not sent in orders for free Clinistix according to Robert S. Tillett, M.D., chairman of the KSMA Diabetes Committee. Chairmen of the County Diabetes Committees should order the Clinistix through the KSMA. All doctors are asked to take part in the program and check urine samples free for the week of the drive.

Last year approximately 55,000 free tests were made and 857 proved cases were reported. Approximately 1600 previously unknown diabetics have been found since the first drive began in 1951.

Other members of the KSMA Committee are: Richard E. Davis, M.D.; Central City; Lewis Dickinson, M.D., Glasgow; Frank H. Moore, M.D., Bowling Green; and John H. Willard, M.D., Harlan.

American Habits To Be Studied At AMA Clinical Meeting

The AMA Clinical Meeting to be held in Denver, November 26-30, will feature a study of the medical aspects of American habits. William Covode, M.D., Denver, is chairman of the section of the program which will include such topics as "The Coffee Break," "The Psycho-Stabilizers," "Psycho-Sexual Aspects," "The Pet in the House," "Automobile Driving," and "The Cocktail Hour."

Chemotherapy in cancer, an area in which knowledge is growing rapidly, will be another important feature of the meeting. Subjects in this area will include: "A Study of Chemotherapeutic Agents in Malignancy," "Chemotherapy of Leukemia and Malignant Solid Tumors in Children," "Chemotherapy as an Adjuvant to Cancer Surgery," and "Enhancement of Radiotherapy by Oral Methotrexate."

Several papers have been scheduled to report some of the new findings in the area of antibodies and antigens. Subjects include: "Autoimmune Disorders," "Thyroiditis," "Rheumatoid Arthritis," and "Molecular Aspects of Antibody and Production and Specificity." Other topics of interest in the area of antibodies and antigens include "Lupus Erythematosis," "Insulin Resistance" and "Homografts."

Suicide will be analyzed in a section that will be of importance to the clinician to assist him in recognizing symptoms and taking preventive steps among his patients. Topics on this subject will include: "Statistics and Public Health Significance," "Causes, and "Prevention."

Joe Miller Appointed To AMPAC Position

Joe D. Miller, formerly executive director of the Kentucky Tuberculosis Hospital Commission from 1949 to 1957, has been appointed to the same position of the American Medical Political Action Committee. The selection was announced September 2 by Gunnar Gundersen, M.D., La Crosse, Wisconsin, chairman of the committee.



Mr. Miller

For the past two years Kentucky was one of five states serviced by Mr. Miller as a member of the AMA Field Service staff. KSMA's two Legislative Council co-chairmen, John C. Quertermous, M.D., Murray—for national affairs; and Robert D. Shepard, M.D., Lexington—for state affairs, expressed appreciation for the most valuable assistance Mr. Miller has given Kentucky; expressed their regrets at his leaving, and extended best wishes for his continued success.

The recently created committee, according to Doctor Gundersen, a past-president of the AMA, will provide the medical profession with an organization for more effective participation in political and government affairs. Headquarters for the committee will be 520 North Michigan Avenue, Chicago.

Mrs. Earl W. Roles, Prospect, president of the Woman's Auxiliary to the Kentucky State Medical Association, is the only woman on the five-member AMPAC.

Mr. Miller, a native of Smith Grove, Ky., and a graduate of the University of Kentucky, has been a member of the staff of the American Medical Association since leaving the TB Commission.

During 1955 he served as president of the Kentucky Junior Chamber of Commerce and as a member of the Board of Trustees of the Kentucky Hospital Association from 1954 to 1956. He and his wife and two children live in Wheaton, Ill.

New Blue Shield Index Reported To AMA

Blue Shield representatives appeared before the AMA's Council on Medical Service at the Annual Meeting in New York City in June. The recently developed Professional Services Index which is to be used in serving national accounts was described.

The Council accepted the report, and commented on it in its own report to the House of Delegates: "The Council commends to the individual state medical associations a careful study of this national services index."

The House of Delegates approved the Council's report and reaffirmed its recommendation that the state medical associations undertake a thorough study of the Index.

Postgraduate Programs Listed Through January

The KSMA Postgraduate Medical Education Office wishes to focus attention upon the immediately forthcoming Postgraduate Course on "RECENT ADVANCES IN THERAPEUTICS." This program will be held in Pikeville, Kentucky, at the Green Meadow Country Club on October 19, 1961. The registration is scheduled to begin at approximately 1:00 P.M., and as in previous courses, there will be ample time provided for discussion and question and answer periods following each presentation.

Detailed information on these programs which are issued by this office may be obtained from the Postgraduate Medical Education Office, 104 West Chestnut Street, Louisville 2. The telephone number is JUniper 7-7135.

The complete listing follows:

October

Weekly through 1961	One week training in the field of OB & GYN, each week during 1961, with the exception of October 23-28; limitation to two physicians per week; fee of $50.00 includes room at Louisville General Hospital, if desired; 42 hours of Category I Credit granted by the AAGP; enrollment should be made at least two weeks before desired participation.
15	Sixth Annual Session on Rheumatic Diseases, Ohio State University, Columbus 10, Ohio.
17	Postgraduate course, "Surgery," University of North Carolina, to be held at Asheville, N. C., afternoon and evening sessions.
18	Postgraduate course, "Surgery," University of North Carolina, to be held at Morganton, N. C., afternoon and evening sessions.
18-20	Postgraduate course, "Obstetrics & Gynecology," University of Tennessee, to be held at John Gaston Hospital, Memphis.
19	Postgraduate Course, "RECENT ADVANCES IN THERAPEUTICS," Green Meadow Country Club, Pikeville, Kentucky.
19	KAGP Seminar, Maysville, Kentucky.
24	Postgraduate course, "Medicine," Universit of North Carolina, to be held at Asheville, N. C., afternoon and evening sessions.
25	Postgraduate course, "Medicine," University of North Carolina, to be held at Morganton, N. C., afternoon and evening sessions.
25-26	John Walker Moore Seminar, Louisville Society of Internists, Dr. Stuart Graves.
25	KAGP Seminar, Mammoth Cave, Kentucky.
25-26	Postgraduate course, "Minor Surgery and Office Orthopedics," University of Buffalo, Buffalo, New York.
26	Fall Seminar at Our Lady of Peace Hospital, Louisville, Dr. Hollis Johnson, to be held in the auditorium, afternoon and evening sessions.
27	Annual Fall Clinical Conference of the Lexington Clinic, to be held at the Campbell House Hotel in Lexington, Dr. John B. Selby.
30-Nov. 24	Postgraduate course, "Psychiatry," Ohio State University, Columbus 10, Ohio.
31	Postgraduate course, "Medicine," University of North Carolina, to be held at Asheville, N. C., afternoon and evening sessions.
31-Nov. 2	Postgraduate course, "Advances in Pediatric Diagnosis and Practice," Medical College of Georgia, Augusta, Ga.

November

1	Postgraduate course, "Medicine," University of North Carolina, to be held at Morganton, N. C., afternoon and evening sessions.
1	Postgraduate course, "Forensic Medicine," University of Buffalo, Buffalo, N. Y.
2	Postgraduate Course, "OBSTETRICS & GYNECOLOGY," Hotel Ritz, Paducah, Kentucky.
3	Symposium on Trauma and Disaster Medicine, University of Virginia, Charlottesville, Va.
7	Postgraduate course, "Medicine," University of North Carolina, to be held at Asheville, N. C., afternoon and evening sessions.
8	Postgraduate course, "Medicine," University of North Carolina, to be held at Morganton, N. C., afternoon and evening sessions.
8-9	Postgraduate course, "Dermatology," University of Buffalo, Buffalo, N. Y.
9	Postgraduate Course, "ANESTHESIOLOGY," Louisville General Hospital, Louisville, Kentucky.
9-10	A two-day symposium to be given by the University of North Carolina at Chapel

(Continued on Page 990)

(Continued from Page 989)

Hill, N. C., general topics have not yet been decided upon at this time.

14-16 Postgraduate course, "Fractures in General Practice," Medical College of Georgia, Augusta, Ga.

17 Conference on Chemotherapy in Cancer, University of Virginia, Charlottesville.

27-30 AMA Clinical Meeting—Denver.

29-30 Postgraduate Course, "Clinical Pharmacology & Therapeutics," University of Buffalo, Buffalo, N. Y.

December

13-14 Postgraduate course, "Use and Interpretation of Diagnostic X-Ray," University of Buffalo, Buffalo, N. Y.

14 Fourth Annual Norton Memorial Infirmary Seminar, Louisville.

January 1962

10-Mar. 14 Postgraduate Course, "ELECTROCARDIOGRAPHY INTERPRETATION," Wednesday evenings, Louisville General Hospital, Louisville.

23-25 Postgraduate course, "Obstetric Problems in Private Practice," Medical College of Georgia, Augusta, Ga.

Psychiatric Seminar To Be Held Oct. 26

The Second Annual Psychiatric Seminar will be held Thursday, October 26 at Our Lady of Peace Hospital, Louisville. The seminar is sponsored jointly by the psychiatric staff of the hospital and by the Jefferson County Chapter of the American Academy of General Practice.

Hollis Johnson, M.D., president of the hospital staff, announces that the following members of the staff will participate in the program: John P. Bell, M.D.; John D. Trawick, M.D.; Arthur R. Kasey, M.D.; George Doyle, M.D.; Frederick C. Ehrman, M.D.; and Joseph Goldstein, M.D. The program has been submitted to the AAGP for four hours of Category 1 Credit.

Guest speaker for the dinner program will be Joseph B. Parker, Jr., M.D., Lexington, professor and chairman of the department of psychiatry, University of Kentucky Medical Center. His topic will be "Neurotic Reactions and the Practice of Medicine."

John M. Hall, M.D., is associated with **O. L. Davis, M.D.,** in a general practice in Scottsville. A 1960 graduate of the University of Louisville School of Medicine, he interned at the Medical Center, Columbus, Ga.

NOTE

To County Society Secretaries and Members

Annual AMA dues will be increased $10 on January 1, 1962, and an additional $10 on January 1, 1963, following action by the AMA House of Delegates in New York, June 26. When this increase becomes effective, the annual dues for active members will be $35 a year in 1962 and $45 in 1963. This is the first AMA dues increase in 12 years.

Cancer Society Makes Grants of $157,832

At a meeting of the Kentucky division, American Cancer Society, Porter Mayo, M.D., Lexington, was elected president to succeed Richard F. Grise, M.D., Bowling Green.

John R. Crockett, Louisville, succeeds Victor H. Englehard as board chairman; Mrs. Mary Bayless, Lexington, was elected secretary; and Harold Hardy, Shepherdsville, is the new treasurer.

Grants totaling $157,832, were allocated for research projects and training of medical personnel. Five research grants went to faculty members of the University of Kentucky College of Medicine. They were: $11,109 to John H. Githens, M.D.; $18,611 to Douglas Rees, M.D.; $15,756 to William H. Knisely, M.D.; $4,000 to Ben Eiseman, M.D.; and $14,692 to Harold D. Rosenbaum, M.D.

Other grants were: $14,400 to St. Joseph Hospital, Lexington; $45,200 to the University of Louisville School of Medicine; $2,400 to Norton Memorial Infirmary, Louisville; and $20,460 to St. Joseph Infirmary, Louisville.

Doctor Kuhns Is Author Of New Book

Dwight M. Kuhns, M.D., Harlan, is one of 27 contributors to Volume V of the series "Preventive Medicine in World War II." The book, "Communicable Diseases Transmitted Through Contact or By Unknown Means," is the sixteenth in the over-all series, "History of the Medical Department, U. S. Army, in World War II," prepared under the direction of the Historical Unit of the U.S. Army Medical Services.



Dwight M. Kuhns, M.D.

Doctor Kuhns, director of the pathology department at Harlan Memorial Hospital, is also consultant to the affiliated Miners Memorial Hospitals in the southern area. He served in the Medical Corps from 1929-1953 and was at one time chief of pathology services at the Walter Reed Army Hospital, and deputy director of the Armed Forces Institute of Pathology. He is currently Chief Consultant in Pathology to the United States Army, and chairman of the Laboratory section of the American Public Health Association.

A 1929 graduate of the University of Louisville School of Medicine, Doctor Kuhns was one of KSMA's Centennial Speakers. He is a co-author of the chapter on bullis fever in the recently released book.

Iowa Society Changes Name

On September 1, the Iowa State Medical Society changed its name to the Iowa Medical Society. An organization of 2500 physicians, the Society has been in existence for over 100 years.



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County Society Reports

McCracken County

At the May meeting of the McCracken County Medical Society, problems of the aged were discussed by John C. Quertermous, M.D., Murray. Doctor Quertermous represents the KSMA on the Governor's Commission on Aging. He spoke on Forand type legislation in connection with Social Security and more specifically the King Bill H. R. 4222 and the Anderson Bill 909 as they relate to the practice of medicine. After commenting on the Kerr-Mills Law, he pointed out that it will only be as good as the doctors and hospitals make it and encouraged all members present to make it work. He stated that if the Kerr-Mills Law fails, we will have Social Security socialized medicine, plus Kerr-Mills and the best thing we can do now is to make Kerr-Mills work. Following Doctor Quertermous' talk, there was a discussion by Doctors Higdon, Pace and Johnson.

Doctor Higdon reported on his trip to Washington, D. C. He said Congressman Mills told the visiting doctors that the Kerr-Mills Law was the best that they could come up with and that it was up to the doctors to accept and implement this law in a sincere manner. He said that he thought is was medicine's only hope of stemming the tide. A number of members discussed the operation of the program.

Doctor Pace reported from Blue Shield that many people feel that doctors are increasing the charges of patients undergoing surgical procedures who are insured. He stated that the Indiana Plan was being discussed at the State Level.

At the June meeting of the Society, a letter from the Kentucky Trudeau Society was read stating that speakers on thoracic disease were available. The Personal Health Card put out by the AMA was demonstrated. It was decided to dispense with summer meetings on a regular monthly basis, and to call a meeting only if necessary.

Muhlenberg County

The proposed revision of the Constitution and By-laws, given initial reading at the last meeting, was read again. The revision was unanimously adopted.

A communication from N. L. Bosworth, M.D., Lexington, of the KSMA Council on Public Relations, was presented, in which attention was devoted to the desirability of emergency call systems. After considerable discussion, this was referred to the Usage Committee of the Medical Staff, Muhlenberg Community Hospital, for comment and recommendation.

The Board of Censure presented a report on their study of various problems of medical discipline. They submitted a resolution to be submitted to the KSMA House of Delegates requesting that the KSMA implement recommendations made by the AMA House of Delegates at the 1961 annual meeting. This was unanimously adopted.

George F. Brockman, M.D., Greenville, submitted a report on the proposed addition of the "Indiana Plan" to Blue Shield in Kentucky. After considerable discussion, the Delegate to the KSMA was instructed to forward the adoption of this provision at the Annual Meeting.

A scientific presentation on "Enchondromata" was given by George H. Rodman, M.D.; David Orrahood, M.D.; Gaithel L. Simpson, M.D.; Robert Mobbs, M.D.; and George F. Brockman, M.D.

The Medical Examination Publishing Co., Inc., announces the publication of the latest addition to their series of Medical Examination Review Books—Volume 8: Psychiatry and Neurology. This volume offers a complete review of current concepts in psychiatry and neurology in the form of 1200 multiple-choice questions and completely referenced answers. The book, priced at $6.00, is available at bookstores, or may be obtained directly from the publisher at P. O. Box 36, Fresh Meadows, Flushing 65, New York.

"Auditory Screening for Infants," a 15-minute sound, color film has been produced by the Child Growth and Development Study of the Johns Hopkins University and the Division of Maternal and Child Health of the Maryland State Department of Health. The purpose of the film is to stimulate interest in an auditory screening technique for infants which is an effective procedure for early detection of hearing impairments and which may also indicate possible abnormalities in motor coordination and mental capacity. For further information, write Mr. John F. De Ley, Bureau of Preventive Medicine, Maryland State Department of Health, 301 West Preston Street, Baltimore 1, Md.

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drugs anonymous

One of the several hastily conceived and potentially dangerous suggestions for reducing drug costs is generic-name prescribing. The proponents of generic-name prescribing claim that it will lower drug costs significantly and—through supervision by the Federal Government—provide quality equivalent to that of trademarked drugs. We maintain that these claims are false. Here are some authoritative answers to the principal questions posed by generic-name prescribing.

How much money would be saved if all prescriptions were written for generic-name drugs?

"The [Rhode Island] Division of Public Assistance examined 10,000 drug prescriptions for welfare recipients for the purpose of determining the actual savings . . . of generic versus trade-name drugs. The drugs had cost $28,000. Substituting generic drugs whenever possible would have provided a saving of less than 5 per cent. Syracuse has made a similar study of drug costs with comparable results."

Rhode Island Medical Journal,
January, 1961

Are the savings worth the risk of sacrificing quality?

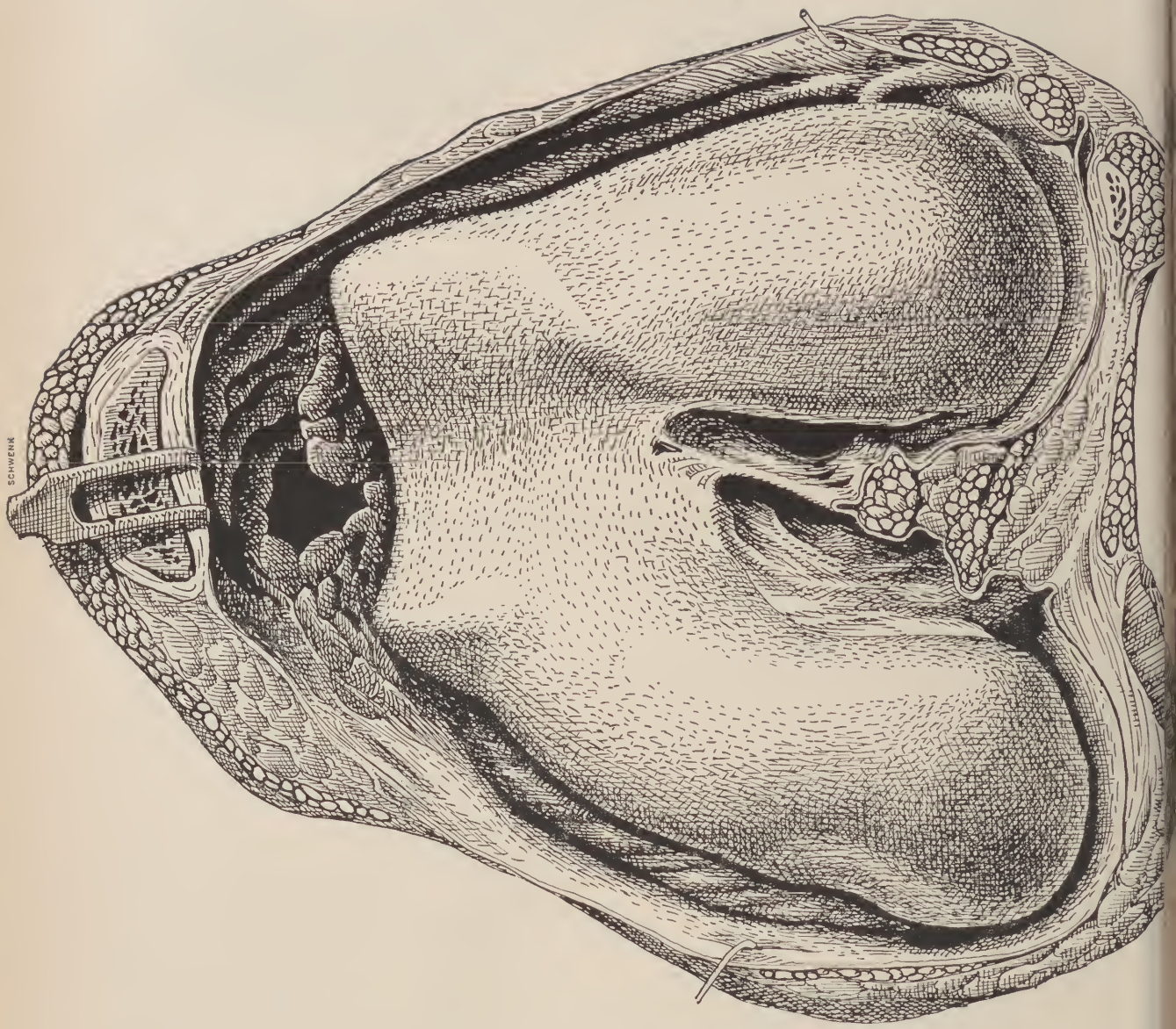
". . . it is unsafe [to prescribe generically] because there is not sufficient policing of our standards. . . ."

Lloyd C. Miller, Ph. D.
Director of Revision of the U.S.P.

"The naive belief that, if a product was not good, the FDA would prohibit its sale is just not realistic. . . . it is completely impossible for the FDA to check every batch of every product of every manufacturer. . . . Hence the integrity and reputation of the manufacturer assume unusual significance where drugs and health products are concerned."

Albert H. Holland, M.D.
formerly Medical Director of the
Food and Drug Administration

Smith Kline & French Laboratories, Philadelphia



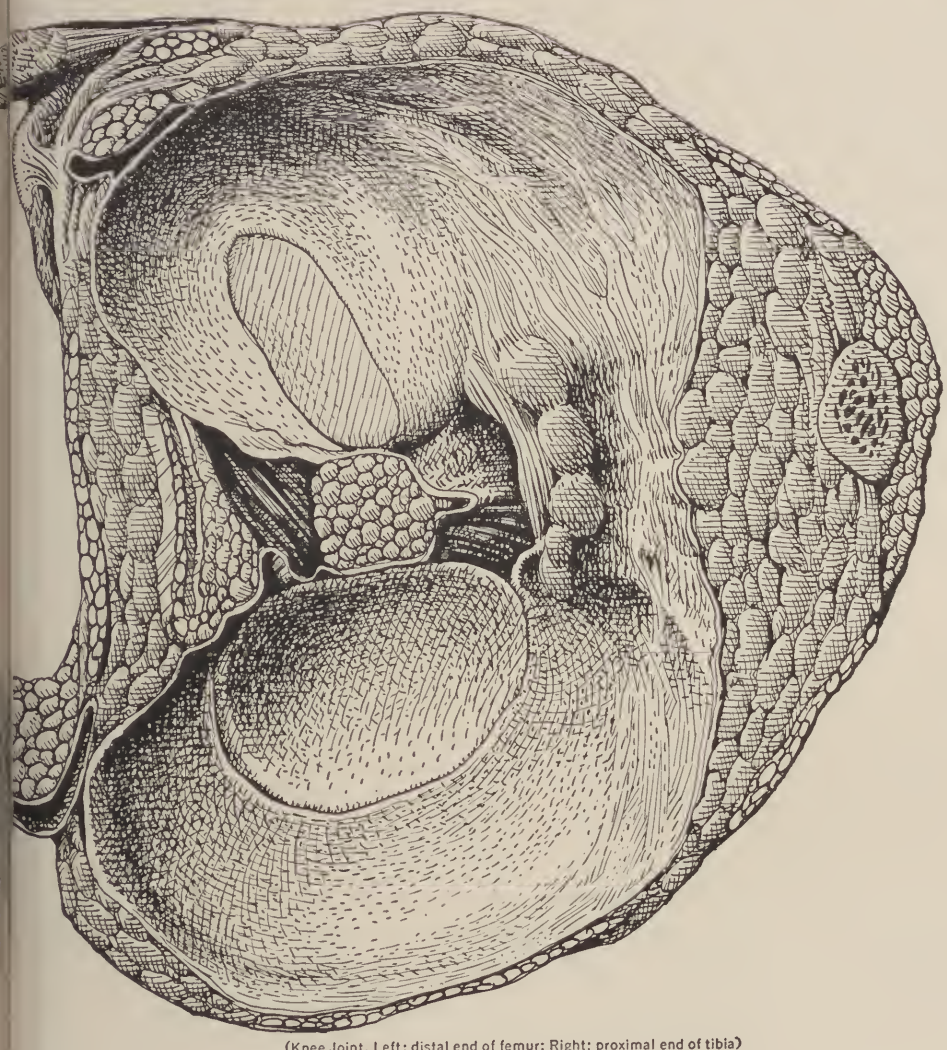
because patients are more than arthritic joints... controlling inflammatory symptoms is frequently not enoug

Even cortisone, with its severe hormonal reactions, can effectively control inflammatory and rheum-
toid symptoms. But a patient is more than the sum of his parts – and the joint is only part of a whc
patient. Symptomatic control is but one aspect of modern corticotherapy, because what is good for t
symptom may also be bad for the patient.

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ARISTOCORT is an outstanding "special purpose" steroid when the complicating problem is increased appetite and weight gain, sodium retention and edema, cardiac disease, hypertension or emotional disturbance and insomnia.

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In Memoriam

CALVIN G. ARNOLD, M.D.
Louisville
1885-1961

Calvin Garnett Arnold, M.D., Louisville, a retired surgeon, died August 29. He was 76. A 1910 graduate of the University of Louisville Medical School, he retired from active practice some 20 years ago. While active, he was president of the Jefferson County Medical Society, the Louisville Obstetrical and Gynecologic Society, and of the medical staff at Kentucky Baptist Hospital.

A native of Versailles, Ky., Doctor Arnold served in World War I in England and France as a captain in the Army Medical Corps. He also invented several surgical instruments.

H. P. DUFF, M.D.
Hazard
1884-1961

A Perry County physician for the past 40 years, H. P. Duff, M.D., died August 31 after a short illness. Doctor Duff was a graduate of the University of Louisville School of Medicine. He was 77.

NELSON A. JETT, M.D.
Covington
1876-1961

A practicing physician in Covington for over half a century, Nelson A. Jett, M.D., died August 26 at Booth Hospital after a brief illness. Doctor Jett received his medical degree from the University of Louisville in 1906 and celebrated his 50th year as a practicing physician several years ago. He had retired just recently.

He was a past president of the Booth Hospital medical staff and treasurer of the Anesthetists Society of Ohio. He was 84.

JAMES FRANK LYNN, M.D.
Bowling Green
1879-1961

James F. Lynn, M.D., a retired Union and Webster County physician, died August 16 at City-County Hospital, Bowling Green. He graduated from the Hospital College of Medicine, Louisville, in 1905, and practiced in Union and Webster counties for 53 years.

R. Douglas Barton, M.D., who has practiced medicine in Lebanon since 1955, is moving to Louisville where he will be on the staff of Veterans Hospital. Doctor Barton had practiced in Campbellsville before going to Lebanon.



Coca-Cola, too, has its place in a well balanced diet. As a pure, wholesome drink, it provides a bit of quick energy.. brings you back refreshed after work or play. It contributes to good health by providing a pleasurable moment's pause from the pace of a busy day.

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confirmed dependability in sinusitis is just one reason why



According to a recent report* on the effectiveness of Terramycin in 106 cases of upper respiratory tract infection: "The response in sinusitis was particularly gratifying, as both acute and chronic cases were controlled within an average of five days."

"It was the impression of the hospital staff that oxytetracycline [Terramycin] was not only better tolerated, but more effective than other antibiotics habitually used."

The results reported in this and many other studies confirm the vitality of Terramycin for broad-spectrum antibiotic therapy and demonstrate why —increasingly—the trend is to Terramycin.



In brief

The dependability of Terramycin in daily practice is based on its broad range of antimicrobial effectiveness, excellent toleration, and low order of toxicity. As with other broad-spectrum antibiotics, overgrowth of nonsusceptible organisms may develop. If this occurs, discontinue the medication and institute appropriate specific therapy as indicated by susceptibility testing. Glossitis and allergic reactions to Terramycin are rare. Aluminum hydroxide gel may decrease antibiotic absorption and is contraindicated.

More detailed professional information available on request.

another reason why the trend is to Terramycin—*versatility of dosage form:*

TERRAMYCIN Syrup/Pediatric Drops

125 mg. per tsp. and 5 mg. per drop (100 mg./cc.), respectively—deliciously fruit-flavored aqueous forms . . . preconstituted for ready oral administration

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New York 17, N. Y.

*Jacques, A. A., and Fuchs, V. H.: J. Louisiana M. Soc. 113:200, May, 1961.

Pfizer *Science for the world's well-being®*

Dear Doctor:

Reports from our representatives indicate that many physicians would appreciate simplification for prescription-writing purposes of the names of Terramycin products in both the "plain" and the "Cosa" dosage forms.

The "Cosa" forms originated, you may recall, on the basis of clinical evidence of enhanced antibiotic absorption when glucosamine is employed in oral administration. To permit each physician individually to study this evidence and choose which form he would prefer to prescribe, we offered Terramycin in both forms—that is, in the regular Terramycin forms without glucosamine, and in the "Cosa" forms with glucosamine.

This distinction appears to be no longer necessary since glucosamine, a highly acceptable excipient for oral antibiotics, now is being incorporated uniformly in all such forms, thereby simplifying nomenclature and your prescription writing.

Accordingly, and effective immediately, forms incorporating glucosamine will be offered simply as Terramycin without the "Cosa" prefix.

To make clear just which forms are affected, please refer to the brief tabulation (below) of Terramycin dosage forms both *before* and *after* this change. We are also requesting our representative to call on you at an early date to answer any questions that may arise.

We feel certain that this action, prompted by your comments and those of many other physicians, will simplify your writing of prescriptions for Terramycin products.

We welcome your comments on this action and on any other phase of our operations, since it is our objective to render every service as efficiently as possible to our friends in the medical profession.

Sincerely,
PFIZER LABORATORIES

The following table indicates the former name and the current name of Terramycin systemic preparations:

FORMERLY NAMED	NOW NAMED
Cosa-Terramycin® Capsules	**Terramycin**® Capsules*
Cosa-Terrabon® Oral Suspension	**Terramycin** Syrup
Cosa-Terrabon Pediatric Drops	**Terramycin** Pediatric Drops

and simpler names for these Terramycin-containing formulations:

Cosa-Terrastatin® Capsules	**Terrastatin**® Capsules
Cosa-Terrastatin for Oral Suspension	**Terrastatin** for Oral Suspension
Cosa-Terracydin® Capsules	**Terracydin**® Capsules

. . . and these names remain unchanged:

Terramycin Intramuscular Solution
Terramycin Intravenous

**Terramycin Capsules* without glucosamine *are no longer available.*

The clinical versatility of Terramycin is enhanced by its specialized dosage forms adapted to individual needs—*another reason for the trend to Terramycin.*

NEWS ITEMS

C. B. Creech, M.D., Middleburg, announced his retirement from the practice of medicine on August 21. Doctor Creech, a 1907 graduate of the Medical Department of the University of Louisville, has practiced in the Middleburg area for 54 years.

Bruce Thompson, M.D., Horse Cave, has been elected president of the Caverna Junior Chamber of Commerce. **John C. Ayers, Jr., M.D.**, Cave City, was chosen as first vice president of the group at its meeting August 10.

A 1958 graduate of the University of Cincinnati Medical School, **George T. Donovan, M.D.**, has opened an office for general practice in Erlanger. Doctor Donovan, a native of Covington, interned at Cincinnati General Hospital and served for two years with the Naval Medical Corps.

A 1944 graduate of the University of Tennessee Medical School, **Robert D. Eastridge, M.D.**, has begun the practice of general surgery in association with the Butterworth Clinic, Murray. Doctor Eastridge interned at Scott and White Clinic, Temple, Texas, and served as a captain in the U. S. Army Medical Corps. He had a general practice in Catlettsburg from 1948 to 1955 before taking residency training at Vanderbilt-Thayer and St. Thomas Hospitals, Nashville, Tenn. From 1959 to 1961 he held a preceptorship at Columbia Veterans Hospital, Columbia, S. C.

A 1949 graduate of the Medical School of George Washington University, **Anne Dunbar Richman, M.D.**, is practicing pathology in association with **Edward J. Fadell, M.D.**, at Methodist Evangelical Hospital, Louisville. Doctor Richman interned and took residency training at Delaware Hospital. She took additional residency training as assistant pathologist at D. C. General Hospital, Washington, D. C. A native of Brooklyn, N. Y., she has her American Board Certificate in Clinical Pathology and Pathologic Anatomy. Doctor Richman has been previously associated with A. W. Freshman, M.D., and S. K. Kurland, M.D., Denver, Colo; and the Pulmonary, Mediastinal and ENT Branch of the Armed Forces Institute of Pathology.

Stanley Hammons, M.D., is associated with **W. E. Becknell, M.D.**, and **James L. Becknell, M.D.**, in a general practice in Manchester. Doctor Hammons, a native of Clay County, received his medical degree from the University of Louisville in 1960 and interned at Louisville General Hospital. He served for two years with the U. S. Air Force.

Ray A. Cave, M.D., has a general practice in Leitchfield in association with **Charles Bland, M. D.**, and **Patrick O'Neill, M.D.** Doctor Cave received his medical degree from the University of Louisville in 1960 and interned at St. Joseph Infirmary, Louisville.

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Editorial

(Continued from Page 987)

and their implications in disease has been scheduled.

It is now possible to get bids and delivery dates on a full-fledged nuclear power plant for private industry. In fact, at least one of these plants already has been built. In the decade ahead there will be many more nuclear reactors in everyday use in many geographical areas.

Every possible safety precaution is taken in the installation and operation of a reactor, but there always is the human element, and accidents will happen. The physician in practice, sooner or later, likely will be faced with the problem of treating injuries from reactor accidents.

Specialists in this area will present several papers that will give those of us in practice considerable basic knowledge on how to treat patients suffering from reactor accidents.

I have listed only a few of the many highlights of the clinical program for the November meeting. There will be many other equally interesting and informative presentations.

The winter meeting is designed specifically for the clinician in practice. Let me repeat: the program this year is the best in the splendid history of this meeting.

Leonard W. Larson, M.D.
President, American Medical Association

News Items

A former McLean County general practitioner, **Ben C. Stigall, M.D.**, has opened an office in Owensboro for a practice limited to Ear, Nose and Throat. A 1948 graduate of the University of Louisville School of Medicine, Doctor Stigall interned at Great Lakes Naval Hospital. He took residency training at Oklahoma City VA Hospital, Dallas VA Hospital and Texas Children's Hospital. He has served on two occasions with the U. S. Navy.

An office for the practice of general surgery has been opened in Danville by **Kearney B. Daniel, Jr., M.D.**, a native of Jackson. Doctor Kearney, a 1956 graduate of the University of Louisville School of Medicine, interned and took residency training at Jackson Memorial Hospital, Miami, Fla. He served as a sergeant in the Marine Corps for three years.

Dewey E. Cummins, M.D., has begun general practice in Brooksville. Doctor Cummins, who practiced previously in Nicholasville, is a 1953 graduate of the U. of L. School of Medicine. He interned at Good Samaritan Hospital, Lexington, and served with the U. S. Navy Air Corps.

Roy J. Moser, M.D., Covington, has begun the practice of internal medicine in association with **C. C. Hugan, M.D.** A 1954 graduate of the Stritch School of Medicine of Loyola University, Chicago, Doctor Moser took his internship at Good Samaritan Hospital, Cincinnati, and residency training at Veterans Hospital, Louisville. He took residency training at Henry Ford Hospital, Detroit, too, where he also held a fellowship in Hypertension in 1960-61. He served as a captain in the U.S. Army Medical Corps at Nartin Army Hospital, Ft. Benning, Ga., from 1956 to 1958.

Harold Jack Kosasky, M.D., is assistant professor of obstetrics and gynecology with the University of Louisville School of Medicine. A native of Winnipeg, Manitoba, Canada, Doctor Kosasky received his medical degree from the University of Manitoba in 1953. He interned at Deer Lodge and Grace Hospitals, Winnipeg. He took residency training in general surgery at Colonel Belcher Hospital, Calgary, Alberta; and in psychiatry at Warren State Hospital, Warren, Pa. Additional residency training was taken at the University of Chicago and as an exchange scholar at the University of Durham, England.

Milton A. Honigman, M.D., has begun general practice at Middlesboro Memorial Hospital. A native of Baltimore, Md., Doctor Honigman received his medical degree from Temple University, Philadelphia, Pa., and interned at Lutheran Memorial Hospital, Chicago, Ill. He served as Lt. Colonel with the U. S. Army Medical Corps for 15 years and has had a general practice at Alexandria, La.

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Fall PG Seminar In Progress

The Jefferson County Chapter of the Kentucky Academy of General Practice is holding its annual Fall Postgraduate Seminar on October 4, 11, 18, and 25, in the Medical Arts Building, Louisville.

All participants are Louisville physicians. The program, submitted for eight hours of Category I Credit by the AAGP, follows:

October 4

7:30 "Rheumatoid Arthritis," William P. Peak, M.D.
8:35 "The Management of the New Diabetic," Lloyd G. Yopp, M.D.

October 11

7:30 "Differential Diagnosis of Thyroid Disease and the Relative Importance of Various Tests to Determine Toxicity," Malcolm D. Thompson, M.D.
8:35 "The Office Detection and Management of Allergic Phenomena," Norman K. Cohen, M.D.

October 18

7:30 "Heart Murmurs," Armond T. Gordon, M.D.
8:25 "The Valuation of Pulmonary Insufficiency," Douglas David, M.D.

October 25

7:30 "Infertility—the Methods of Diagnosis and Treatment," Rudolph F. Vogt, M.D.
8:25 "Ovarian Dysfunction—and the Use of the Newer Progestational Agents in its Treatment," Harold W. Baker, M.D.

Dr. Keightley To Speak In Mexico

A Harrodsburg physician, James M. Keightley, M.D., will speak to the Conference of the Association of American Schools in the Republic of Mexico, to be held October 15-18, in Guadalajara, Mexico.

Doctor Keightley, who is a member of the Harrodsburg Board of Education, will speak on "Problems Faced by School Boards of Education in the United States." He will also work with Conference delegates on school health problems.

AMA Sets Disaster Conference

The American Medical Association's Conference on Disaster Medical Care will be held in Chicago, November 4-5. It is designed to brief medical representatives of all county and state medical societies concerning medical care during disaster conditions.

A Kentucky physician, Carroll L. Witten, M.D., Louisville, will speak the second day of the Conference on "Team Approach—Health Mobilization" and will participate in a symposium on "Training of Allied Health Professions and Services."

Members and associates of the Kentucky and Tennessee chapters of the American College of Physicians are urged to attend the Kentucky-Tennessee Regional Meeting of the College in Louisville on November 18.

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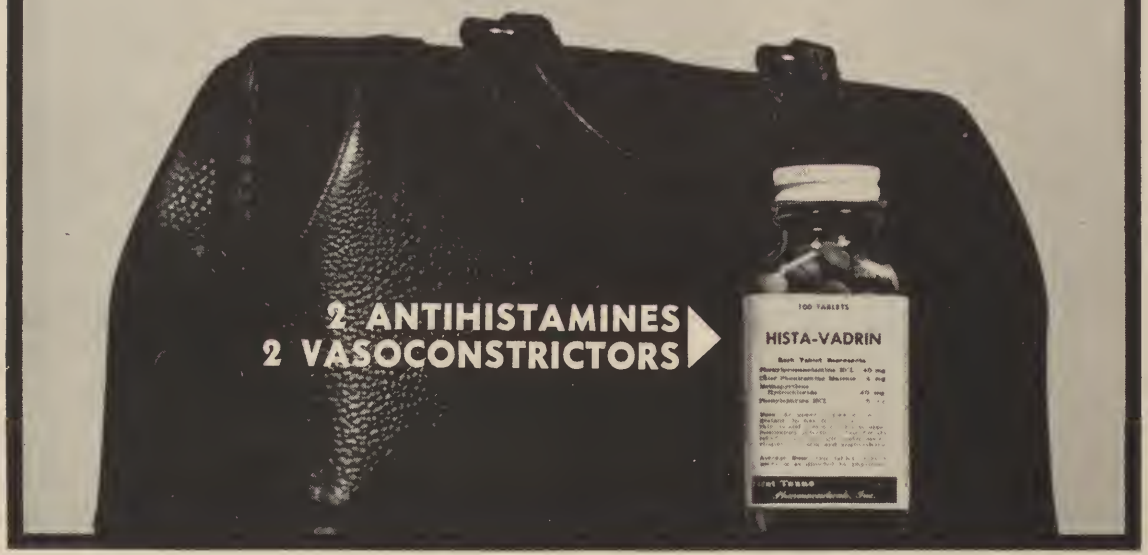
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Dosage:

Children from 6 months to 1 year, 1/4 teaspoon; 1 to 3 years, 1/2 to 1 teaspoon; 3 to 6 years, 1 to 2 teaspoons; 6 to 12 years, 2 teaspoons. Every four to six hours as needed.

How Supplied:
Bottles of 16 fl. oz.

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A General Consideration of Pyelonephritis; Recent Advances

(Continued from Page 984)

and the peculiar ability to react like Antabuse® in individuals who are taking this drug and drinking alcoholic beverages while on treatment.

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KSMA Lists New Members

New members who have joined the KSMA since the last report in The Journal are:

Donald Stephens, M.D., Berry
Joe Withers, M.D., Berry
James Craig, M.D., Greenville
Joseph D. Stokes, M.D., Greenville
Robert F. Mobbs, M.D., Greenville

Russell E. Teague, M.D., state commissioner of health, announces the appointment of Charles L. Weaver, health physicist, as director of the Division of Radiological Health. Mr. Weaver has been assigned by the U. S. Public Health Service to the Kentucky State Department of Health. He announces that Kentucky is joining the Public Health Service National Radiation Surveillance Network with the establishment of a sample collection station for determining radioactive fallout in air samples.

The International Medical-Legal Society, organized in 1960, held its first meeting in Honolulu in February 1961. The second annual meeting is planned for February 1962 at the same location. Speakers of national recognition from both the Medical and Legal professions will be on the program. Physicians subject to malpractice suits as well as medical legal work and attorneys involved in similar suits will find the meeting informative. For further information, contact William P. Hauser, M.D., Executive Secretary, 1206 South 11th, Tacoma, Washington.

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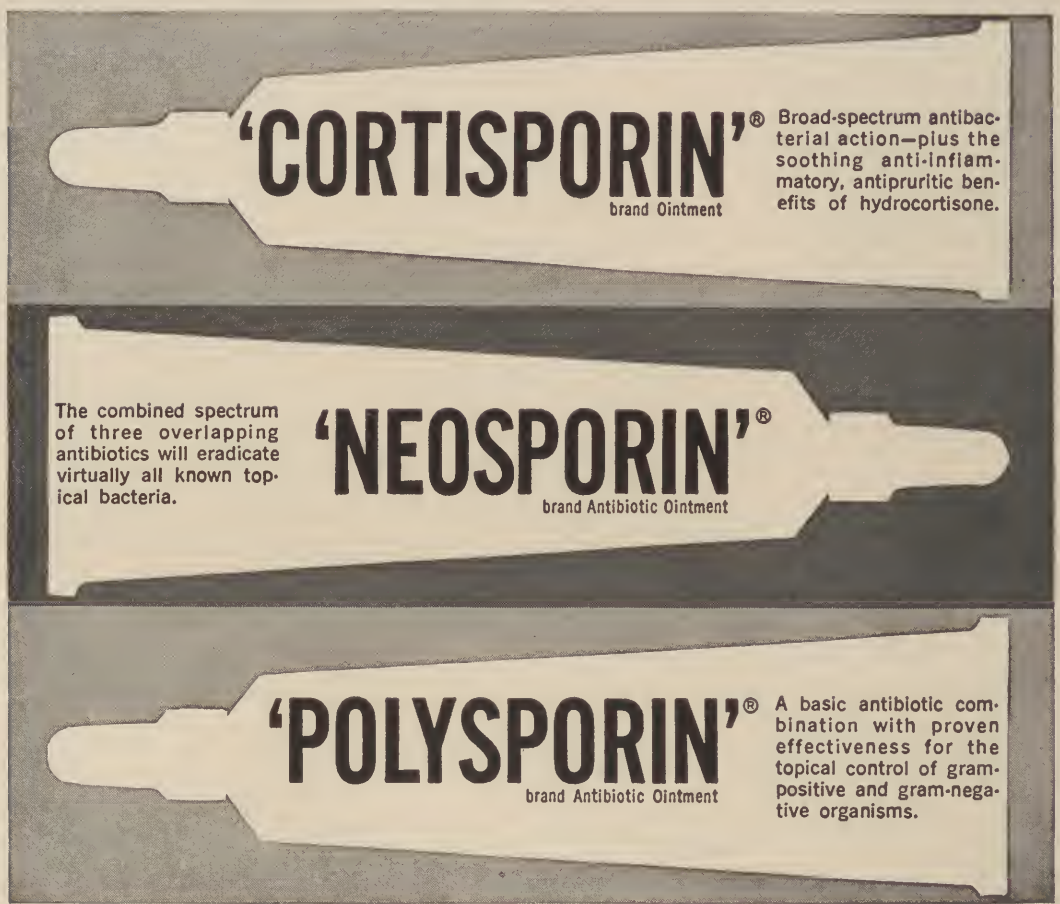
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Pertinent Paragraphs

The American Thyroid Association, Inc., again offers the Van Meter Prize Award of $500 to the essayist submitting the best manuscript of original and unpublished work concerning "Goiter—especially its basic cause." The Award will be made at the Annual Meeting of the Association at the Roosevelt Hotel, New Orleans, La., May 9-12, 1962. A place on the program will be reserved for the winning essayist. Essays may cover either clinical or research investigations and should not exceed 3,000 words. They are due by January 1, 1962. Contact Theodore Winship, M.D., Secretary, 430 North Michigan Ave., Chicago 11, Ill.

The fields of surgery, urology, medicine, obstetrics-gynecology, orthopaedics, pediatrics, neuro-surgery, and clinical neurology will be discussed at the 15th Annual Postgraduate Assembly, sponsored by the San Diego County General Hospital. The Assembly will be held November 1-2 at the Hospital in San Diego, Calif. For further information, contact the Registrar, James E. Sandell, M.D., c/o San Diego County General Hospital, San Diego 3, Calif.

The Mississippi Valley Conference on Tuberculosis will be held in Chicago, Ill., October 12-14. The program for the conference includes a full day of medical sessions held by the Mississippi Valley Trudeau Society. Seven medical papers and two panels will be presented. Dorothy T. Magallon, M.D., formerly director of Tuberculosis Control with the Kentucky Department of Health, Frankfort, will participate in one of the panel discussions. For further information on the conference, write the Tuberculosis Institute of Chicago and Cook County, 1412 West Washington Boulevard, Chicago 7, Ill.

The Kentucky and Tennessee Chapters of the American Society of Internal Medicine will meet in Nashville, Tenn., on November 21.

The number of people in the United States protected by health insurance has gone from one out of eleven people in 1920, to three out of four persons in 1961, according to a statement by the Health Insurance Institute. In 1940, 5,000,000 Americans had surgical expense insurance, while at the end of 1960, 121,000,000 people had such protection. Regular medical expense insurance covered only 3,000,000 Americans in 1940, but last year more than 87,000,000 persons were covered. The Institute said that 92 per cent of persons with health insurance have both hospital and surgical expense insurance, and 66 per cent have hospital, surgical, and regular medical expense insurance.

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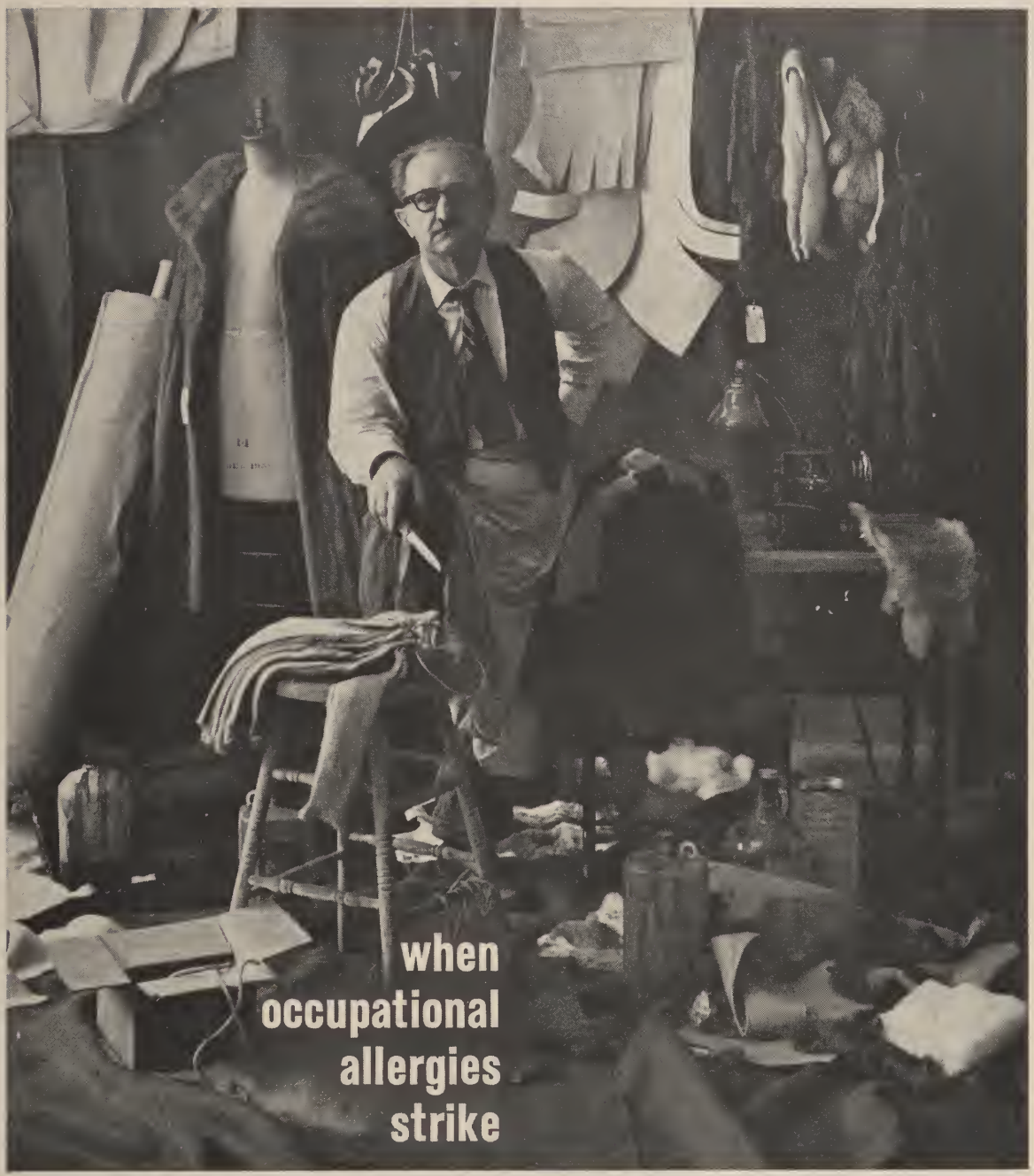
News Items

A 1956 graduate of the University of Louisville School of Medicine, **Harry A. Hamilton, M.D.**, has become associated with **Harold B. Barton, M.D.**, Corbin, in the practice of general surgery. Doctor Hamilton interned at St. Mary's Hospital, Evansville, Ind., and took residency training at Louisville General Hospital. He served for two years with the U. S. Air Force.

Alberto Mazzoleni, M.D., has accepted a teaching appointment with the University of Kentucky Medical Center. A native of Milan, Italy, Doctor Mazzoleni received his medical degree from the University of Milan. He interned at Miriam Hospital, Providence, R. I., and took residency training at Lemuel Shattuck Hospital, Boston, and Boston City Hospital. He held a fellowship with Beth Israel Hospital, Boston, and took graduate study in cardiology, Harvard University.

Evalyn G. Evans, M.D., has begun the practice of pediatrics in Ashland. A native of Lynch, Doctor Evans is a 1958 graduate of the University of Tennessee Medical School, and interned at Baroness Erlanger Hospital, Chattanooga, Tenn. Residency training was taken at T. C. Thompson Children's Hospital, Chattanooga.

William E. Hathaway, M.D., has joined the University of Kentucky Medical Center where he limits his practice to pediatrics. A native of Ardmore, Oklahoma, Doctor Hathaway received his medical degree from the University of Oklahoma; interned at the U. S. Naval Hospital, Brewerton, Wis.; and took residency training at the New York-Cornell Medical Center. He has served with the U. S. Navy Medical Corps and had a previous pediatric practice in Colorado Springs, Colo.



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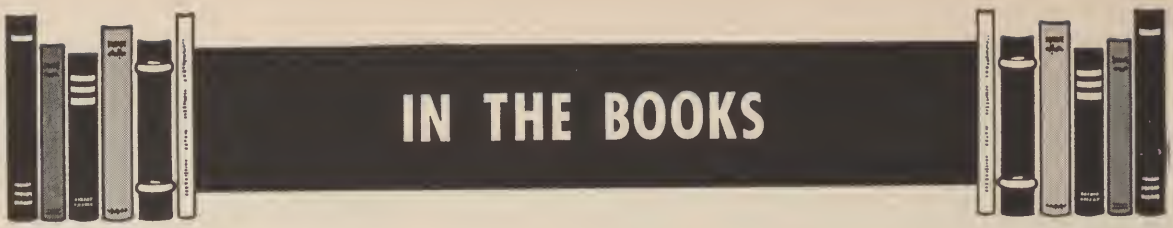
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DANIEL DRAKE (1785-1852), PIONEER PHYSICIAN OF THE MIDWEST: by Emmet Field Horine, M.D.; published by University of Pennsylvania Press, Philadelphia, Pa.; 425 pages; price, $6.00.

America's distinguished historian and medical educator, John Shaw Billings, M.D., when commenting upon Daniel Drake's *Principal Diseases of the Interior Valley of North America* in 1876, stated that it was the work "of a man whose fame, as compared with that of his contemporaries, will probably be greater a century hence than it is today, and whose name, even now, should be among the first on the list of the illustrious dead of the medical profession of the United States."[1] Doctor Billings' prophecy was well founded, for this definitive biography details the many talents of Daniel Drake and establishes his undeniable greatness as a pioneer physician, medical educator and author.

In reading this biography one is amazed and oft times envious of the prodigious quantity and infinite variety of work that Daniel Drake was able to perform and perform well. Drake's extraordinary foresight concerning the needs of his fellow man and his well conceived plans for providing for them are factually presented and constitute the primary theme of the biography.

Drake was strong-minded and talented. Petty jealousies were aroused and there were many of his contemporaries who sought notoriety by detracting from the efforts of this tireless benefactor. The numerous attacks by these nefarious persons, often members of his own profession, provide the secondary theme.

Doctor Horine's presentation is a masterpiece of documentary evidence in support of the real Daniel Drake. One could scarcely devote 32 years to the scholarly pursuit of an individual possessed of such unquenchable enthusiasm and talent as Daniel Drake, without developing a fond admiration for him. Doctor Horine is to be congratulated for writing this biography from fact, not "feeling." Indeed, from the text, it is difficult to detect the author's emotional attachment to Drake.

The author's familiarity with American history is apparent in the skill with which he has placed the reader in proper contemporary perspective throughout the narrative. Frequent footnote citations of original source material provide a soundness of scholarship seldom found in biographical writing. The correlative material thus cited should provide source material for the minds and pens of a number of future historians.

I have enjoyed reading this biography and recommend it as excellent reading for all who would know the real Daniel Drake and his contributions to the growth and strength of the medical profession of the United States from 1805 to 1852.

Eugene H. Conner, M.D.

[1] *Billings, John Shaw: A Century of American Medicine, 1776-1876 Philadelphia, Henry C. Lea, 1876. pp 312-313.*

CARDIOVASCULAR DYNAMICS: by Robert F. Rushmer, M.D.; published by W. B. Saunders Company, Philadelphia and London; 503 pages; price $12.50.

Cardiovascular Dynamics is an extensive revision, enlargement and reorganization of a book originally published under the title *Cardiac Diagnosis: A Physiologic Approach*. The components of the cardiovascular systems has been one of Doctor Rushmer's major interests for years and he adequately emphasizes the role of the nervous system in the control and regulation of the circulation. The pathologic physiology of cardiovascular diseases is lucidly presented in terms of the altered dynamics and the most recent advances in these areas are described. The only flaw this reviewer can find is the lack of any description of the physiological mechanisms involved in splitting of the second heart sound. There is no reference to normal splitting with respiration or to pathologic splitting of the second heart sound in certain cardiac disorders.

This volume was designed for students of the cardiovascular system in the broadest sense—from first year medical students to experienced cardiologists. Doctor Rushmer has accomplished his purpose by an exhaustive survey of the voluminous literature. Many examples of his own outstanding investigations are included and these serve admirably to explain many poorly understood or doubtful facets of the circulation. This text is highly recommended for careful reading.

Charles J. McGaff, M.D.

CHILDBIRTH WITH HYPNOSIS: by William S. Kroger, M.D.; published by Doubleday and Company, Inc., Garden City, New York; 216 pages; price, $3.95.

This book was written principally for the expectant mother. The subject matter is presented in a clear and forceful manner.

Although the author makes a good case for the use of hypnosis in obstetrics, he does not stop there. He tells the patient what constitutes good prenatal care; the advantages and disadvantages of hypnosis; and says when it should not be used.

This book would offer great help to a patient interested in learning how to relax and to use hypnotic

methods in her pregnancy, labor and delivery. Her physician would find it useful also.

Doctor Kroger discusses the psychological and emotional changes associated with pregnancy, delivery, location and the postpartum period. This aspect of pregnancy is covered better here than in most books of this nature, familiar to the reviewer.

There are many case histories and testimonials of patients who have experienced pregnancy and delivery with the aid of hypnosis. This should be reassuring to any expectant patient reading this volume.

This short book of 215 pages can easily be read in an evening. It should prove very useful to patient and doctor concerning the use of hypnosis in obstetrics. It could be subtitled "A Guide to a Safe and Normal Pregnancy—using hypnotic methods."

Glenn W. Bryant, M.D.

Washington News

(Continued from Page 950)

Doctor Terry attributed "the progressive decline in polio since 1955" to the Salk vaccine. He said that through Aug. 5 only 234 paralytic cases had been reported this year, as compared "with 13,850 for the polio season of 1955, the first year in which the Salk vaccine became available in limited quantities."

The AMA said the licensing of the live virus vaccine marked "another step forward" in the fight against polio. The Association predicted the new vaccine would be "a valuable weapon against epidemics of Type I polio." However, the AMA again urged that everyone complete a series of Salk shots.

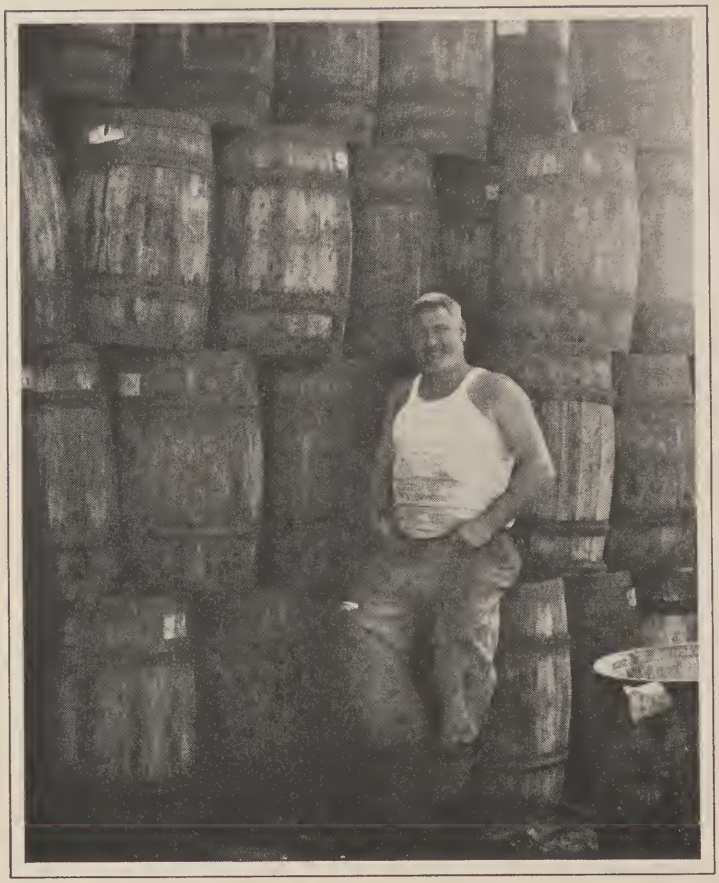
"Until such time as oral vaccines against all three types are available, the Salk vaccine remains the only protection available against all types of paralytic polio," the AMA said.

Thomas E. Egan, M.D., a native of Cincinnati, has begun the practice of pediatrics in association with **William Temple, M.D.**, Covington. Doctor Egan is a 1958 graduate of the University of Cincinnati Medical School. He interned at St. Mary's Hospital, Cincinnati, and took residency training at Children's Hospital of Michigan in Detroit.

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Dosage: Adults, 1 Caplet (200 mg.) three or four times daily; children (5 to 12 years), from 50 to 100 mg. three or four times daily.

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In the presence of bacterial infection, taking a culture to determine bacterial identity and sensitivity is desirable—but not always practical.

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SUPPLIED: Capsules, each containing Panmycin* Phosphate (tetracycline phosphate complex), equivalent to 250 mg. tetracycline hydrochloride, and 125 mg. Albamycin,* as novobiocin sodium, in bottles of 16 and 100.

USUAL ADULT DOSAGE: 1 or 2 capsules 3 or 4 times a day.

SIDE EFFECTS: Panmycin Phosphate has a very low order of toxicity comparable to that of the other tetracyclines and is well tolerated clinically. Side reactions to therapeutic use are infrequent and consist principally of mild nausea and abdominal cramps.

Albamycin also has a relatively low order of toxicity. In a certain few patients, a yellow pigment has been found in the plasma. This pigment, apparently a metabolic by-product of the drug, is not necessarily associated with abnormal liver function tests or liver enlargement.

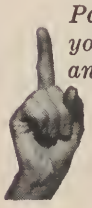
Urticaria and maculopapular dermatitis, and a few cases of leukopenia have been reported in patients treated with Albamycin. These side effects usually disappear upon discontinuance of the drug.

CAUTION: Since the use of any antibiotic may result in overgrowth of nonsusceptible organisms, constant observation of the patient is essential. If new infections appear during therapy, appropriate measures should be taken. Total and differential blood counts should be made routinely during prolonged administration of Albamycin. The possibility of liver damage should be considered if a yellow pigment, a metabolic by-product of Albamycin, appears in the plasma. Panalba should be discontinued if allergic reactions that are not readily controlled by antihistaminic agents develop.

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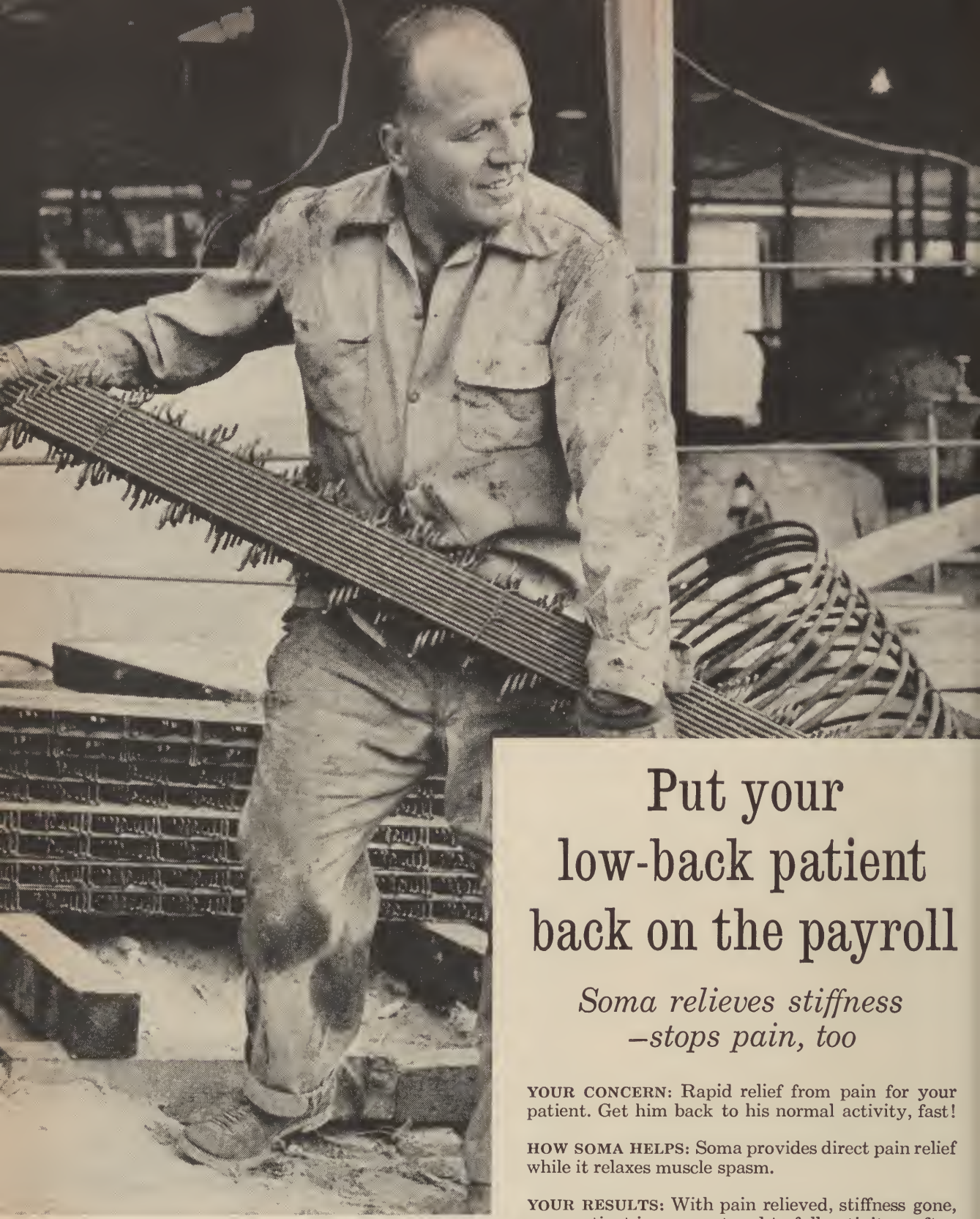
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HOW SOMA HELPS: Soma provides direct pain relief while it relaxes muscle spasm.

YOUR RESULTS: With pain relieved, stiffness gone, your patient is soon restored to full activity—often in days instead of weeks.

> Kestler reports in controlled study: *Average time for restoring patients to full activity: with Soma, 11.5 days; without Soma, 41 days.* (*J.A.M.A. Vol. 172, No. 18, April 30, 1960.*)

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STUDY 3 *Weissberg, G.: Clin. Med. 7:1161, 1960.*

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- senile pruritus
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- soap dermatitis
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From the files of the
COMMITTEE FOR THE
STUDY OF MATERNAL MORTALITY



CASE #80—The patient, a 21 year old primigravida, was admitted to the hospital January 3, 1960, with a history of prolonged labor of unstated duration. She was at term according to her menstrual history.

The past history included an appendectomy and right oophorectomy in 1958.

Examination on admission revealed a well-developed, white woman in active labor, with uterine contractions occurring every five to seven minutes. The vertex was presenting in the left occipitoposterior position. The pelvis was estimated to be clinically adequate.

The woman was delivered of a normal eight pound infant with the aid of a wide episiotomy. The anesthesia used was not recorded on the patient's notes. The placenta was easily expelled, and blood loss was apparently slight. There was no record as to whether the cervix and vagina were examined following delivery.

On leaving the birthroom, the patient was in satisfactory condition. The uterus was well-contracted, and the fundus was below the umbilicus.

One hour following delivery the patient experienced a "moderately severe hemorrhage" and went into shock. At examination the uterus was noted to be quite flabby and difficult to outline. Blood was immediately drawn for a blood count and for typing and crossmatching. Apparently no oxytocic infusion was begun. The blood count was recorded as 4,400,000, the hemoglobin as 10 Grams per cent.

As the blood transfusion was to be begun, both the patient and her family notified the hospital staff that she would not allow a transfusion of blood to be given to her, as this was against her religious beliefs. The seriousness of the situation was explained to the patient and her mother, and later to the patient's minister, but to no avail.

The patient's attending physician then advised an exploratory laparotomy to which the patient consented. A hysterectomy was performed with the withdrawal of nearly 1000 cc. of blood; this was returned to the patient as an autotransfusion. Her condition improved for 30-45 minutes, after which she lapsed into an increasing shock with death two hours later.

The death certificate was coded as: Shock due to postpartum hemorrhage.

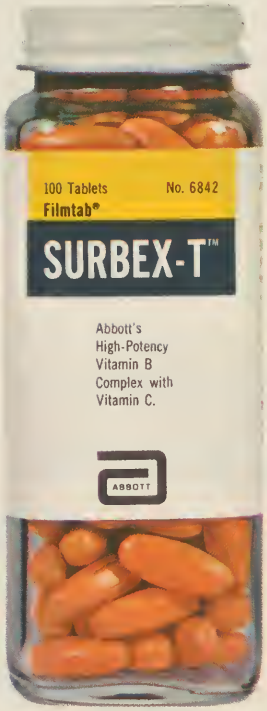
Comments

The Committee classified this case as a direct obstetrical death with preventable factors. The patient should have informed the physician of her religious views regarding blood transfusion early in pregnancy. It was felt that the physician exercised good judgment by not attempting to give the patient the needed transfusion against her will. However, a pitocin infusion throughout labor and the immediate postpartum period would have served to shorten the length of the labor as well as to prevent the postpartum atonic hemorrhage that followed.

Hemorrhage remains the chief cause of maternal deaths in Kentucky. Fifteen (60 per cent) of the 25 maternal deaths in the state in 1960 were due to postpartum hemorrhage. Six of these 15 followed uterine rupture, four accompanied postpartum uterine atony.

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THROUGH
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CH-5535

PUBLIC HEALTH PAGE

Staphylococcal Infections In The Hospital And Community*

RUSSELL E. TEAGUE, M.D., M.P.H. *Commissioner of Health Commonwealth of Kentucky*

DURING recent years medical literature dealing with staphylococcus has been fragmentary with regard to the epidemiology and etiology of this insidious disease which is so frequently underestimated. This makes it difficult to make an estimate of the total incidence of staphylococcus in the complete population of a specific area during a specific period of time. Therefore it is felt that the history and development of this disease should be given serious consideration and evaluation.

For centuries suppuration, pyemia and septicemia were common sequelae of surgery. Suppuration was so common as to be considered a normal phase of post surgery, and if it did not appear, efforts were made to hasten the formation of laudable pus. However, even before Pasteur solved the bacteriological problems involved, others were proving that suppuration was not an essential product of surgery. Reimert T. and Otto H. Ravenholt[1] have pointed out that "as early as 1782, Alanson performed 35 amputations in the Birmingham Infirmary without loss of a single patient or a serious wound infection. He recognized rather fully the value of isolating surgical patients in a sanitary environment" Some analysis of military surgery during the wars of the nineteenth century showed that the danger of pyemia increased in proportion to lack of hygiene and to crowding of wounded patients. It is believed that hospitals were the main source of fatal pyemia then as they are now, and that most of the fatalities were caused by staphylococci.

Lister's principles of antiseptic surgery and the aseptic principle and improved technics of von Bergmann, Schimmelbusch and Halsted greatly reduced infections from surgical wounds. However it appears that staphylococci-caused infection of surgical wounds in hospitals remain a considerable cause of death.

There appears to be substantial correlation historically, between the incidence of staphylococcal disease in newborn infants and their mothers and the use of hospitals for childbirth. Infants which are infected in hospital nurseries are effective vehicles for the transmission of the disease to the mother, to other family contacts and to the other wards in the hospital. The usual chain of this infection seems to be from the nursery to the infant and then to the nursing mother. In October 1956 a survey was made of 15 hospitals in Seattle,[2] where 1,456 mothers and their infants were delivered. In one of these hospitals where 10 per cent of the total deliveries took place, 75 per cent of the mothers who attempted to nurse their infants developed mastitis. This hospital produced 20 per cent of the infant pyoderma, 45 per cent of the maternal mastitis, 100 per cent of the infant mastitis and 75 per cent of the neo-infant staphylococcal disease mortality.

The crowding of hospital patients appears to be one of the important factors in the production of cross-infection in hospitals, particularly in the nurseries. Because of the propensity of those with staphylococcal infection to contaminate their environment, and because of the great capacity of staphylococci to survive apart from human hosts, staphylococcal disease is less dependent upon crowding for its propagation in the hospital than are many other diseases, e.g., streptococcal infection. It has been clearly demonstrated that changing of wound dressings, movement of blankets, and other activities cause rapid and substantial staphylococcal contamination of air. Nasal carriers contaminate their environment especially by transferring organisms with their hands to their clothing, from which staphylococcal-laden particles are subsequently liberated into the air by movement of clothes. Coleback[3] has shown that much of the hospital environment is contaminated with staphylococci by patients with suppurating lesions through the survival of these contaminating organisms in blankets and mattresses. Special precautions must be taken to prevent the indirect transmission of these parasites, which can survive at room temperature for months and even years.

Mortality statistics provide little knowledge of staphylococcus as they are currently collected and analyzed. The Seattle study indicated that only 4 out of 7,837 deaths which occurred in King County during 1956 were attributed to staphylococcal disease. Still other reported information would indicate that this disease was a major cause of more than 100 and probably more than 200 of these deaths during 1956.

There is a growing concern that there exists a correlation between the staphylococcal disease of patients and hospital staff and the contamination of the hospital environment by the staphylococcal parasite. Staphylococcal diseases which are acquired in hospitals are now recognized as a formidable contemporary cause of sickness and death. The solution to this problem can be realized only by improvement of the application of current knowledge and technics by the medical profession to provide sanitary hospital environments and by the wise use of effective epidemiology and preventive measures in an informed community.

**This article was prepared by: Strawn W. Taylor, Director Bureau of Records and Statistics State Department of Health, Frankfort, Kentucky.*

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1. Dr. Reimert T. Ravenholt, Director, Division of Epidemiology and Communicable Disease Control, Seattle-King County Department of Public Health, Seattle, Wash. and Otto H. Ravenholt, Senior Medical Student, University of Minnesota, Minneapolis, Minn.
2. Ravenholt, R. T.; Wright, P.; and Mulhern, M. E. Epidemiology and Prevention of Nursery-Derived Staphylococcal Disease. New England J. Med. 257: 789-795 (Oct. 25) 1957.
3. Colebeck, J. C. Studies in Hospital Infections. I Canad. Services M. J. 12: 563-580 (July-Aug.), 1956.

With about 75 of its 100 members present, the Louisville and Jefferson County Committee on Alcoholism held its organizational meeting September 13 at Norton Memorial Infirmary. **Leslie Van Nostrand, M.D.**, medical director of General Electric, was named temporary chairman.



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1. Kane, S.: Am. Pract. & Digest Treat. *8*:65 (Jan.) 1957.

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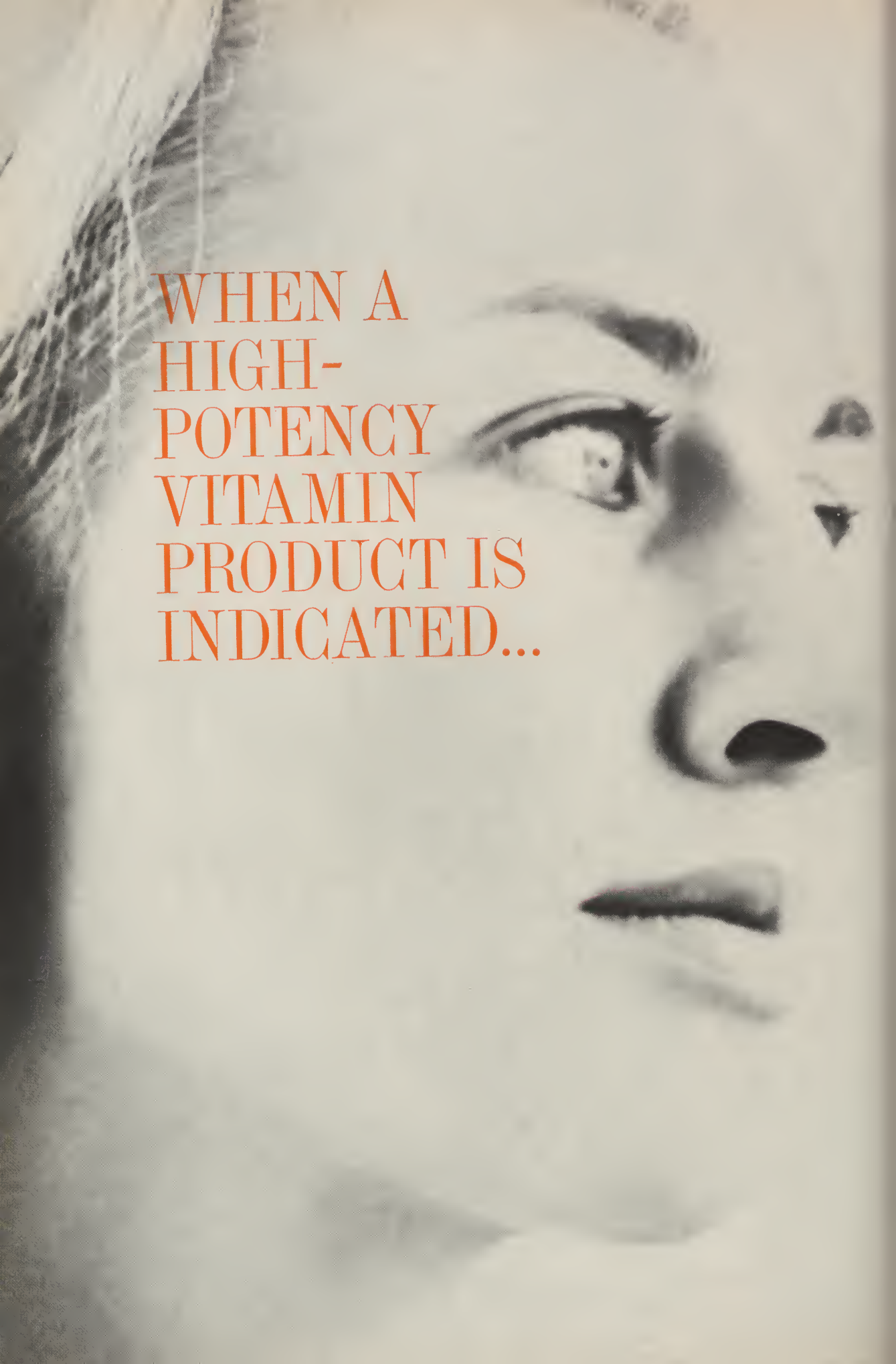
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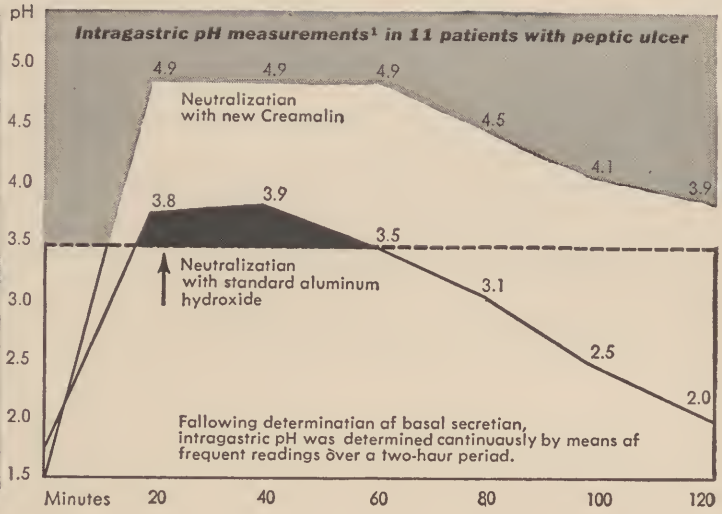
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1. Youmans, J. B.: Am. J. Med. 25:659 (Nov.) 1958

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arthritis "It is our practice to prescribe a multiple vitamin preparation to patients with rheumatoid arthritis simply to insure nutritional adequacy . . ."[3]
3. Fernandez-Herlihy, L: Lahey Clinic Bull. 11:12 (July-Sept.) 1958.

digestive diseases Symptoms attributable to B-vitamin deficiency are commonly observed in patients on peptic ulcer diets.[4] Daily administration of therapeutic vitamins to patients with hepatitis and cirrhosis is recommended by the National Research Council.[5] 4. Sebrell, W. H.: Am. J. Med. 25:673 (Nov.) 1958. 5. Pollack, H., and Halpern, S. L.: Therapeutic Nutrition, National Academy of Sciences and National Research Council, Washington, D. C., 1952, p. 57.

degenerative diseases "Studies by Wexberg, Jolliffe and others have indicated that many of the symptoms attributed in the past to senility or to cerebral arteriosclerosis seem to respond with remarkable speed to the administration of vitamins, particularly niacin and ascorbic acid. These facts indicate that the vitamin reserve of aging persons is lowered, even to the danger point, more than is the case in the average American adult."[6] 6. Overholser, W., and Fong, T.C.C. in Stieglitz, E. J.: Geriatric Medicine, 3rd edition, J. B. Lippincott, Philadelphia, 1954, p. 264.

infectious diseases Infections cause a lowering of ascorbic acid levels in the plasma; and the absorption of this vitamin is reduced in diarrheal states.[7] 7. Goldsmith, G A.: Conference on Vitamin C. The New York Academy of Sciences, New York City, Oct. 7 and 8, 1960. Reported in: Medical Science 8:772 (Dec.10) 1960.

diabetes Diabetics, like all patients on restricted diets, require an extra source of vitamins.[8] "Rigidly limiting the bread intake of the diabetic patient automatically eliminates a large amount of thiamin from the diet. . . .There is some evidence of interference with normal riboflavin utilization during catabolic episodes."[9]
8. Duncan G. G.: Diseases of Metabolism 4th edition W. B. Saunders, Philadelphia, 1959, p. 812. 9. Pollack, H.: Am. J. Med. 25:708 (Nov.) 1958.

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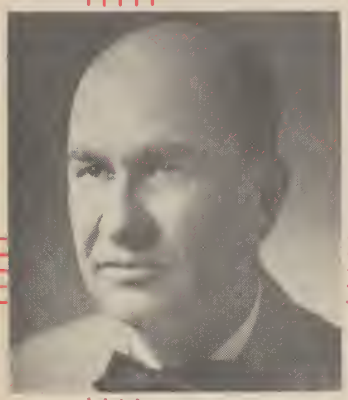
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Our Greatest Natural Resource

THE 1960 census revealed that Kentucky fell way behind in national average during the past decade in population gain. As a result, many of our young people who trained in our state institutions have moved elsewhere for a lifetime of endeavor due to lack of opportunity here.

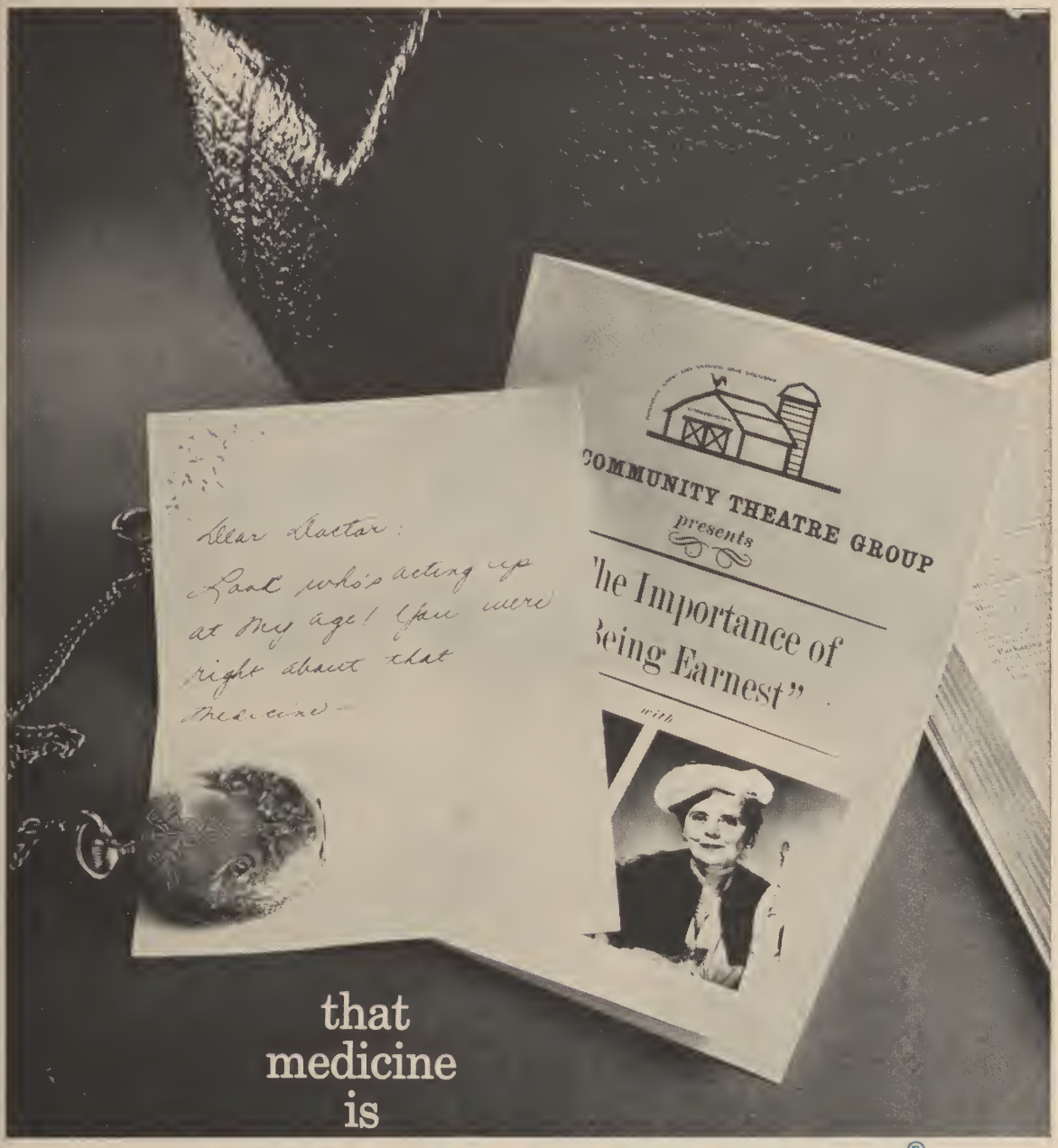
What can be done to make Kentucky more productive of opportunity and what groups are devoting energy and effort in this direction? Much can be done and is being done by such groups as the Kentucky Chamber of Commerce, Natural Resources Development Commission, the University of Kentucky Extension Program, and the Soil Conservation Services.

Our current administration has also done a great deal to improve our lot—not only in the elementary but in the secondary educational program as well—and materially by attracting industry to Kentucky. It has also looked kindly upon programs for conserving our natural resources.

Kentucky, largely rural, ranks third in the United States in its program of rehabilitation of soil and water resources, being exceeded only by Texas and Oklahoma in this respect. These programs will be long term in scope and mark the belated beginning of an intelligent approach to this important matter; preserving productive soil and providing habitat for wild life, etc. Improving the lot of the Kentucky agriculturist will directly raise the per capita income of many of our citizens and raise the standards of living.

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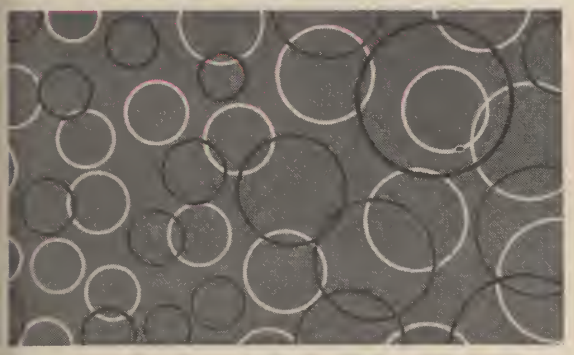
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THE INSURANCE PAGE



Health Insurance Covers 132 Million

A RECORD 132 million Americans were protected by some form of health insurance at the end of 1960, the Health Insurance Institute, which is maintained by the nation's insurance companies, has reported.

During the past year record benefits of $5.6 billion were paid out for persons covered by health insurance, the institute said.

In a review of the past year, the institute estimated the number of persons having hospital insurance had increased by four million to 132 million as of December 31, 1960. Some 120 million had surgical insurance, an increase of three million over the 1959 year-end count.

Regular medical insurance, which helps pay for the cost of doctor calls, protected 86 million persons at the end of 1960; 25 million had major medical insurance, and 43 million had loss-of-income insurance.

The institute said that 73 per cent of the U. S. population had some form of health insurance by the end of 1960. The institute's figures were based on an actual count of persons covered by policies and contracts issued by Blue Cross Plans, insurance companies and other insuring organizations. Allowance was made for duplication of coverage.

The benefit payments of $5.6 billion in 1960 represented an increase of about nine per cent over the $5,175,000,000 paid out in 1959 the institute said.

An interim report on health insurance issued last month by the U. S. Department of Health, Education and Welfare had estimated that "at least two-thirds of the people now living in the United States have some kind of protection." The HEW estimate was derived from an interview survey of approximately 19,000 households during the period July-December, 1959.



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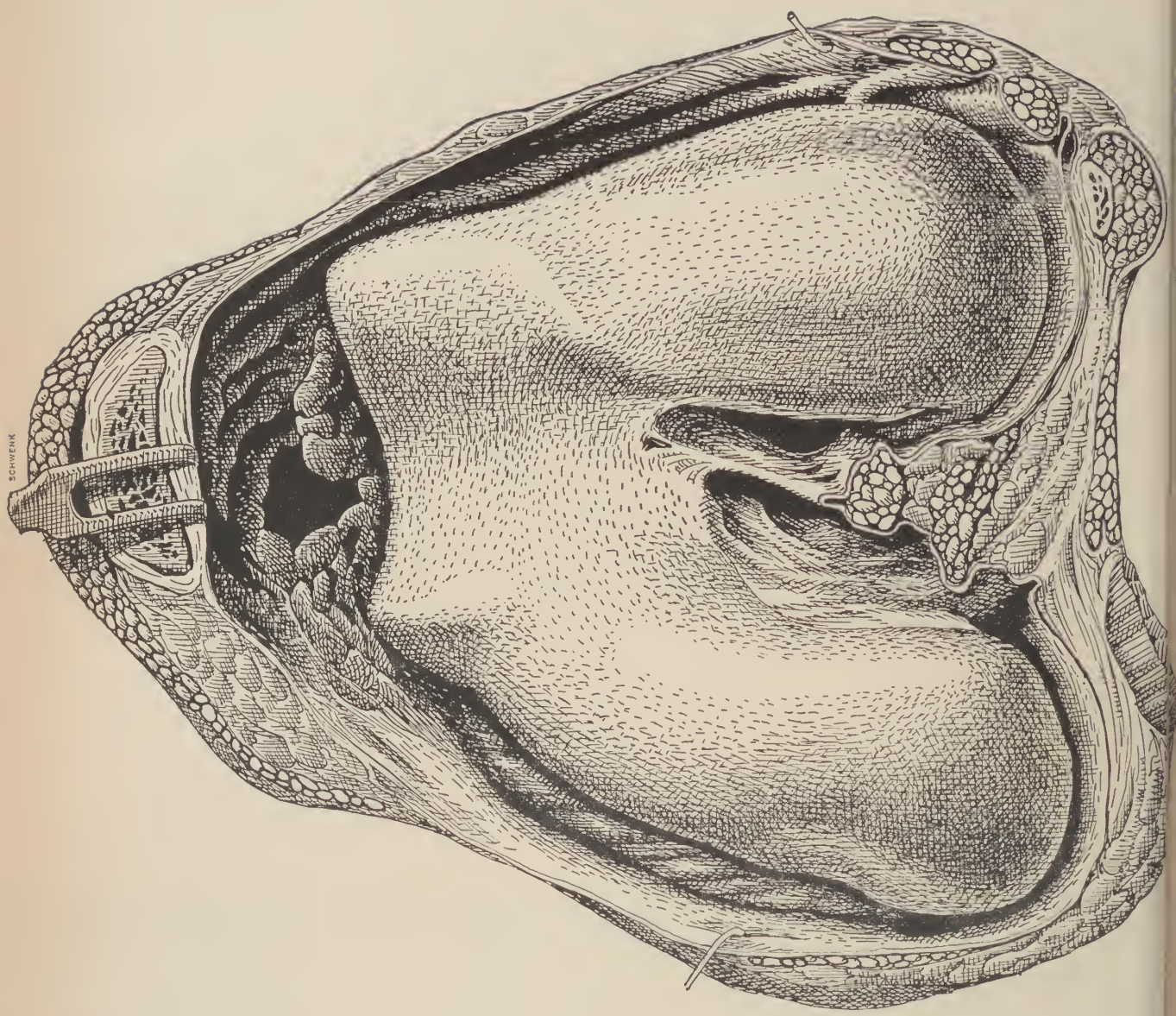
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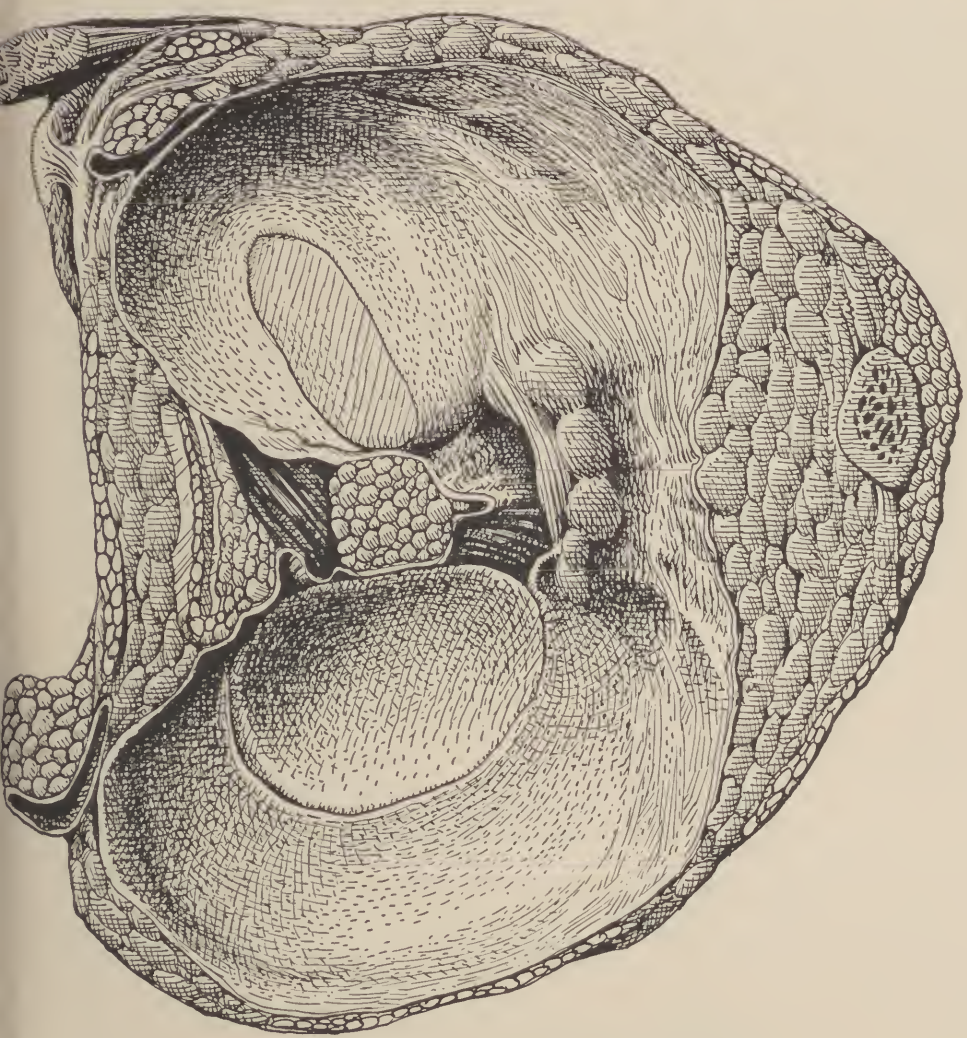
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WASHINGTON NEWS DIGEST



WASHINGTON, D. C.—The American Medical Association and the federal government declared all-out war on medical quacks and charlatans who bilk the sick and gullible of hundreds of millions of dollars each year through useless gadgets, phony nostrums, fake reducing pills and the many other gimmicks of the medicine show trade.

The campaign was launched at the First National Congress on Medical Quackery, under joint sponsorship of the AMA and the U.S. Food and Drug Administration, Oct. 6-7 at the Sheraton-Park Hotel in Washington.

Among the keynote speakers were two top officials in President John Kennedy's cabinet, Secretary of Health, Education and Welfare Abraham A. Ribicoff and Postmaster General J. Edward Day. Leonard W. Larson, M.D., president of the AMA, and Oliver Field, Director of the AMA Department of Investigation, spoke for organized medicine.

Others on the program included Herbert J. Miller, assistant U. S. attorney general in charge of the criminal division; George P. Larrick. commissioner of the FDA, and Paul Rand Dixon, chairman of the Federal Trade Commission.

Other speakers included representatives of the American Cancer Society, the Arthritis and Rheumatism Foundation, and the National Better Business Bureau.

C. Joseph Stetler, director of the Legal and Socio-Economic Division of the AMA presided at the meeting.

Many state and county medical societies from throughout the nation sent representatives to the Congress. They carried back to their societies plans for cooperation with enforcement agencies at the local level and for a step-up of public education on the subject in an accelerated campaign against quacks.

Highlights of the talks included:

—Larson: "We must educate the public thoroughly and effectively. We must wage psychological as well as scientific warfare. We must not only prove the worthlessness of quackery, but we also must establish confidence in sound medical and health care.

"Speaking for the American Medical Association and our 180,000 physician-members, I pledge our efforts to the final eradication of quackery and all its minions and satraps."

—Ribicoff: "The total cost of unnecessary or dangerous medications in this country probably exceeds $1 billion each year. Much of this expense is to men, women, and children who dearly need this money for good medical care or for other necessities of life.

"But quackery's costs in dollars only introduces the story. In terms of false hopes raised, in terms of ugly delusions fostered, in terms of tinkering with human life itself, the cost cannot be measured. The quack flirts with disaster. He challenges the sixth Commandment: 'Thou shalt not kill.' "

—Larrick: "The most widespread and expensive type of quackery in the United States today is in the promotion of vitamin products, special dietary foods, and food supplements. Millions of consumers are being misled concerning their need for such products. Complicating this problem is a vast and growing 'folk-lore' or 'mythology' of nutrition which is being built up by pseudo-scientific literature in books, pamphlets, and periodicals. As a result, millions of people are attempting self-medication for imaginary and real illnesses with a multitude of more or less irrational food items. Food quackery today can only be compared to the patent medicine craze which reached its height in the last century. Especially disturbing is the tendency shown by some big and hitherto respected food concerns to use quackery in their sales material."

—Dixon: "Properly drafted and administered, legislation giving the Federal Trade Commission power to issue temporary cease-and-desist orders would, while observing all the requirements of due process, make it possible to protect the public interest more adequately in many areas.

"Although in the case of food. drug, and cosmetic advertising, the Commission can . . . apply to district courts for temporary injunctions, it would be much more efficient for the Commission itself to issue temporary orders in those cases as well as in others."

—Day: "The peddling of fake medical cures is the most prominent fraudulent activity conducted through the U.S. mails today. This huge 'industry'—and it has grown to that extent—is so prevalent and so widespread that it taxes the manpower of the Postal Inspection Service to the utmost in trying to bring the perpetrators to justice.

"We are doing everything we can to make more of our inspectors available to work on cases of this nature, to the extent it will not jeopardize enforcement in other fields."

Doctor L. Henry Garland, American Cancer Society: "The charlatan is in business to make money and he does so by offering *hope*. He tends to be courteous, optimistic, easily understood by the laymen, and confident that cure can be obtained. His patient does not care that the method used is a secret one, that the testimonials are largely fraudulent,

(Continued on Page 1056)



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Washington News

(Continued from Page 1054)

or that the 'doctor' may not even be licensed. All he knows is that he is being reassured and treated by someone who seems to be interested in him as a person.

"If it is granted that the causes of charlatanism are . . . diverse, it seems obvious that control must be equally diverse—composed of the difficult and slow triad—public education, professional education and continued research in cancer prevention."

—Doctor R. W. Lamont-Havers, Arthritis and Rheumatism Foundation: "That this is a large problem is indicated by the estimated 250 million dollars a year that arthritic victims spend upon unproven, and misrepresented products in a vain attempt to obtain unrealizable relief from their suffering. Not all of these products are quackery in the sense of being useless. Some contain active ingredients—usually salicylates, or apparatus such as vibrators, but are promoted with such misrepresentation of effects that the arthritic fully expects results beyond the capabilities of the drug. Others are outright quackery and include such popular items as alfalfa tea, uranium pads, honey and vinegar, etc. Of particular concern are the widely advertised so-called 'clinics,' chiefly in Missouri and Florida."

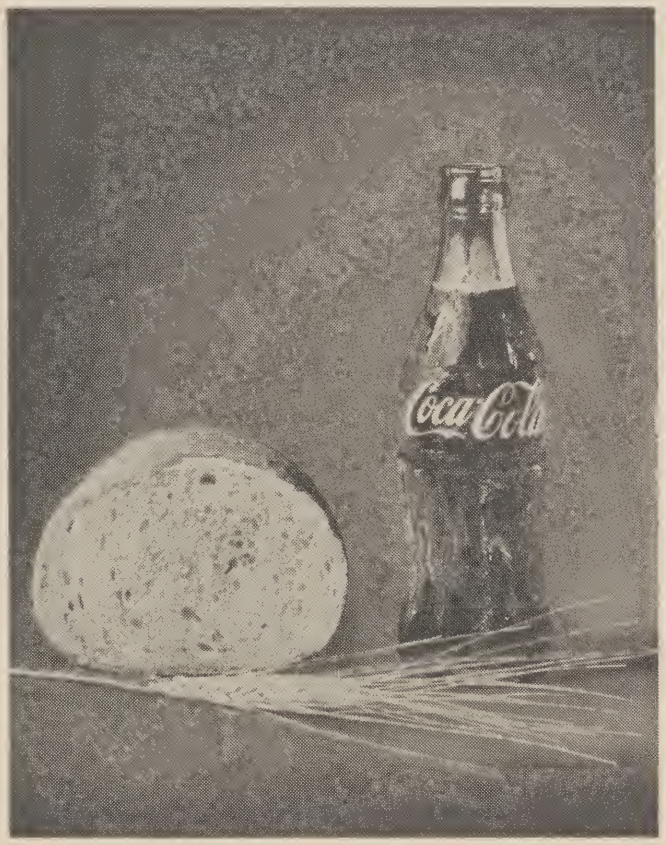
—Field: "We would like to envision the time when we can cease to worry about the medical quack. But it's going to take an awful lot of doing. The Food and Drug Administration, the Post Office Department, the Federal Trade Commission and the Food and Drug groups of many states of the Union, cannot do the job alone. It takes a program which seeks to acquaint the public with the problem, and swings into action quickly when there is a threat to the community or to the nation at large. This takes the help of all interested people—consumer groups, educational groups, religious organizations, and, most of all, those responsible for the education of the American youth . . . The emphasis should be on letting the public know, strengthening the laws where necessary, but, most of all, providing a means of distinguishing between the legitimate medical practitioner and the one who pretends to be one."

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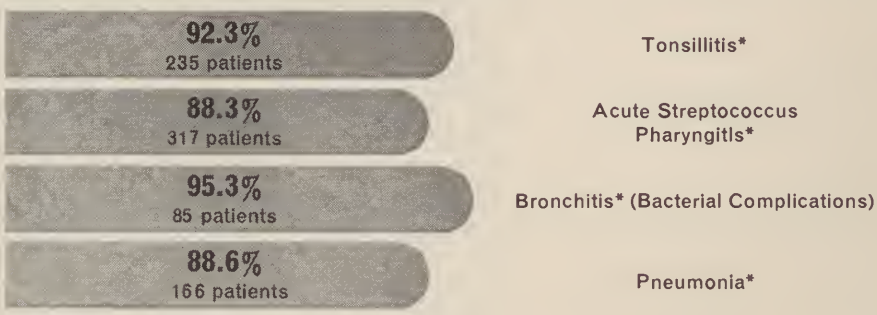
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The Differential Diagnosis Of Acute Upper Abdominal Catastrophies*

HENRY S. COLLIER, M.D.

Louisville, Ky.

The chief differential points between pancreatitis, cholecystitis, and perforated ulcer, the most frequent upper abdominal catastrophies, are outlined.

ONE of the most provocative complaints brought by the patient to the physician is that of sudden, acute, severe, agonizing upper abdominal pain. The causes of such complaints are many, i.e., diseases of the viscera in the upper abdomen, pain referred from lower abdominal viscera upward, and pain referred from diseases of the lower thorax downward. An early correct diagnosis is important because the prognosis will be determined on the type of management and the promptness of instituting correct therapy.

Basically, this problem resolves itself into whether or not the condition present will require surgical intervention. Surgery done in the presence of a nonsurgical entity, such as a coronary occlusion or an acute hemorrhagic pancreatitis, may make the difference between recovery or death. But, on the opposite side of the coin, delaying treatment in an operable emergency, such as a perforated gastric or duodenal ulcer or obstruction of gangrenous bowel, because of an incorrect diagnosis, will doom the success of any later form of therapy.

For the sake of brevity and simplicity, this discussion will consider only the differential diagnosis of the three most frequent causes of acute upper abdominal distress. These are: (1) acute hemorrhagic pancreatitis, a condition in which surgery is contraindicated; (2) perforated peptic ulcer (duodenal or gastric), a condition in which early surgery is imperative; and (3) acute cholecystitis, a condition in which surgery may be done early or delayed. So, actually, what we are discussing is the differentiation of a nonsurgical entity, acute pancreatitis, from the other two conditions, both of which are treated surgically.

Statistical Studies

A knowledge of statistical studies of these three diseases is the first available and important clue. Statistically, their order of frequency is cholecystitis, perforated ulcer, and pancreatitis, with pancreatitis making up about 1 per cent of acute abdominal diseases. Because of its infrequency, pancreatitis is least often considered and the most difficult to diagnose.

*Presented at the third annual Norton Memorial Infirmary Postgraduate Medical Seminar in Louisville, Kentucky, on December 17, 1960.

It has been estimated that in the best, most modernly equipped hospitals, the correct preoperative diagnosis of acute pancreatitis is made in only one third of the cases. The two thirds that are misdiagnosed are about equally mistaken as perforated ulcer and cholecystitis. Somewhere between one half and two thirds of cases of acute pancreatitis are unnecessarily explored. This bears out the fact that acute pancreatitis can mimic any upper abdominal surgical condition, plus the fact that from 20 to 40 per cent of patients with acute pancreatitis also have associated biliary tract pathology.

The age and sex of the patient are helpful hints. Perforated ulcer occurs most frequently in males in their thirties and forties. Pancreatitis is fairly equally distributed between the sexes in their thirties and forties. Cholecystitis is predominant in females forty and beyond. All three diseases, however, may occur in either sex from the teens to senility.

Symptoms

Sudden onset of severe upper abdominal pain is the cardinal presenting symptom in all three diseases. Maximum pain as the initial symptom is more probable with pancreatitis and perforated ulcer than with cholecystitis, although biliary colic can be nearly as agonizing. All characteristically follow soon after the ingestion of a heavy meal or alcohol, but the latter is infrequent in cholecystitis. Past history of typical ulcer pain will be elicited in from 60-80 per cent of patients with perforations. Previous indigesiton and fatty food intolerance can be misleading because of the association of biliary disease with pancreatitis. It is more enlightening to determine where the pain began than where it presents when the patient is examined. The radiation of pain may be helpful when typical. All three may have radiation into the back. Shoulder pain is most suggestive of perforation; right subscapular or interscapular radiation characterizes cholecystitis. A boring pain straight through to the back at the level of the first lumbar vertebra and spreading to the left side of the back at this level characterizes pancreatic pain.

What the patient does to obtain relief is important information. The gallbladder patient is more apt to be active than the others. Walking the floor, tossing in bed, applying heat over the right upper quadrant, and becoming more restless during colicky exacerbations of discomfort are all suggestive of cholecystitis. The patient with perforation may be doubled up by the sudden spillage of gastric or duodenal contents, but he soon wishes to lie quietly. The patient with pancreatitis does not wish to move, but he may sit hunched forward with his knees drawn up, or lie on his side with his knees drawn.

Anorexia, nausea, or vomiting are characteristic of each disease. Vomiting in each is of the reflex type, appearing earliest with pancreatitis. Vomiting frequently will relieve temporarily the biliary colic. No such relief is noted with pancreatitis. Persistent, frequent vomiting, progressing to retching, characterizes pancreatic necrosis and accounts for the early appearance of dehydration and shock. The vomitus in each consists of gastric contents and later bile, rarely becoming fecal, differentiating all three from small intestinal obstruction.

Findings

The outstanding physical findings are: tenderness, rigidity, ileus, distention, fever, and tachycardia. These are all present in each to some degree. In cholecystitis, tenderness and rigidity are more apt to be localized to the right upper quadrant. A palpable mass in this region is diagnostic. Murphy's sign is nearly always present. (This sign is elicited by placing the thumb of the left hand over the right subcostal region in the area of the gallbladder fundus and instructing the patient to take a deep breath. A positive response is obtained by the patient "catching his breath" or having increased pain as the fundus becomes impinged under the thumb.) In perforation, the tenderness is less localized and the early rigidity is characteristically board-like. Breathing is primarily costal and grunting. The absence of liver dullness when elicited is diagnostic. The findings in pancreatitis mimic the other conditions, but the patient appears more ill and prostrate. In the true necrotizing pancreatitis, shock frequently occurs, and with deepening shock, positive abdominal findings will become less prominent. The severe case of pancreatitis, however, has a more characteristic clinical picture than the less fulminating case.

The laboratory findings are not diagnostic unless considered in the light of the entire

clinical picture. Leukocytosis and hemoconcentration may be present in each or none early. Supine, upright, and lateral decubitus x-rays should be done. Visualization of a calculus in the gallbladder region is helpful but not diagnostic, since perforation and pancreatitis occur in patients with gallstones. Pneumoperitoneum is diagnostic of a perforated viscus, but, unfortunately, only 80-85 per cent of perforated ulcers show free air in the peritoneal cavity. An intravenous cholangiogram is helpful in diagnosing acute cholecystitis, but if pancreatitis is associated with an elevated serum bilirubin above 3mg. %, there also will be no visualization of the biliary tree. In one series reported, six out of thirteen patients with pancreatitis had no visualization of the biliary tract following intravenous cholangiograms.

The most reliable single laboratory procedure remains the *early* determination of the serum amylase. This must be done within forty-eight hours of the onset of illness to be diagnostic. Although other abdominal catastrophies, such as perforated duodenal ulcer, gangrenous bowel, and gangrenous acute cholecystitis, will occasionally show a moderate elevation, values well above the maximum normal level are usually found only with acute pancreatitis. It has been recommended that after the first forty-eight hours, determination of the amylase level in aspirated abdominal fluid will also be diagnostic of pancreatitis. Hypocalcemia and hyperglycemia may also be helpful in establishing the diagnosis of pancreatitis.

Conclusion

In conclusion, it is imperative to differentiate surgical from nonsurgical diseases of the upper abdomen. Pancreatitis is diagnosed *only* when it is considered. Every case of upper abdominal pain and tenderness should have an *early* serum amylase determination done in addition to a thorough study of the history, the clinical findings, x-ray, and other laboratory procedures. Panic laparotomies and undue procrastinative procedures are both condemned.

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Empyema in Childhood

The records of 125 patients with empyema, ranging in age from 2 months to 12 years, who were hospitalized between 1941 and 1958, were reviewed; 112 of these had acute empyema and 13 had the chronic form of the disease. Before the advent of antibiotics pneumococcus was the commonest offender, but in recent years *Staphylococcus pyogenes* was the more frequent cause of empyema in childhood. Bronchographic examinations in 56 patients showed little or no damage to the lung from either pneumococcal or staphylococcal infection. The streptococcus was responsible for a greater degree of lung damage, and chronic empyema caused the highest incidence of bronchial complications. Chronic empyema was due to the failure to recognize the condition in 9 patients, and to unsatisfactory drainage in the remaining 4. Intercostal drainage is the treatment of choice in small children, and pleurectomy in older children and adults. The prognosis of empyema has been tremendously improved with the introduction of antibiotic therapy.

—E. Hoffman, Thorax; Vol. 16:128 (June) 1961.

Simulation Of The Acute Surgical Abdomen By Chest Pathology*

W. Burford Davis, M.D.

Louisville, Ky.

Irritation of pleura and diaphragm may mislead the unwary surgeon into the abdomen. These more common forms of chest pathology causing abdominal symptoms are discussed.

SEVERE irritation of the diaphragm will produce enough epigastric spasm to justify the clinical impression of acute epigastric pathology. Physical or chemical trauma of the lower intercostal nerves and their environs will produce spasm and rigidity of the mid and lower abdomen simulating an abdominal crisis.

Lobar Pneumonia

You may have heard surgeons, trained in the era when lobar pneumonia was common, express the adage that a surgical resident's training was not completed until he had treated lobar pneumonia via appendectomy. Since the advent of antibiotics, far fewer patients suffering from lobar pneumonia have had their appendices removed by a happy surgeon who soon became morose. Lobar pneumonia of the right lower lobe, producing symptoms characteristic of appendicitis, is the classic example of chest pathology simulating the acute surgical abdomen.

Trauma

Chest wall trauma will almost always produce severe abdominal spasm. If the chest wall trauma is unilateral, there is generally an absence of spasm on the contralateral side of the abdomen. This is of considerable help in ruling out intraabdominal injury. Where the chest trauma has been bilateral, the problem of determining whether or not there is a ruptured or severely contused abdominal viscus becomes increasingly difficult. When chest trauma involves the lower costal cage anteriorly or laterally, in some cases it may be advisable to do a small laparotomy in order to rule out the possibility of rupture of the liver or spleen. When chest trauma is sufficiently severe to produce a flail chest with paradoxical respiration, stabilization of the costal cage is of utmost importance. Stability of the chest wall must be accomplished before attempting detailed diagnostic procedures in trying to rule out severe abdominal trauma.

Spontaneous Rupture of the Esophagus

Probably laparotomy is carried out unnecessarily in a higher percentage of cases of spontaneous rupture of the esophagus than in any other form of chest pathology. This catastrophic condition results in profound shock, grunting respiration, epigastric spasm, and cyanosis or pallor. Frequently, suprasternal subcutaneous emphysema may be present. Diagnosis can be confirmed by the findings of a hydropneumothorax. The onset of symptoms is sudden and generally associated with vomiting. This condition is most common in alcoholics and frequently occurs when the patient is drunk, thus complicating the clinical picture. Despite our modern armamentarium of good anesthesia, antibiotics, and whole blood transfusions, the mortality from spontaneous rupture of the esophagus is still quite high.

*Presented at the Third Annual Norton Memorial Infirmary Postgraduate Medical Seminar in Louisville, Kentucky, on December 15, 1960.

Empyema

An acute empyema associated with pneumonia, or an empyema caused by the rupture of a lung abscess or neoplasm into the pleural space, will produce extreme pleural reaction and promptly result in marked spasm of the abdomen. Fortunately, the abdominal findings, particularly the spasm, are generally unilateral, and, hence, of considerable assistance in establishing accurate diagnosis. Also, the quality of the respiration and physical signs of the chest are helpful in avoiding a clinical impression of acute abdominal catastrophe.

Incarcerated Hiatal or Diaphragmatic Hernia

The type of vomiting that occurs in an incarcerated hiatal or diaphragmatic hernia is strongly suggestive of a high intestinal or pyloric obstruction. When a hernia of one of these types becomes strangulated or ruptured, there is sufficient diaphragmatic irritation to cause moderately severe epigastric spasm. A rapid downhill course of a patient suffering from such a condition necessitates early diagnosis. Therefore, these are conditions that should be kept in mind when a high obstruction is suspected.

Spontaneous Pneumothorax

Several years ago I was called at 2:00 A.M. by a general surgeon who had a patient on the operating table whom he suspected of having a ruptured abdominal viscus. This patient had had an upright film of his abdomen where no free gas was demonstrated in the abdomen, but he had such exquisite tenderness and board-like rigidity of the abdomen that it was felt that laparotomy was imperative. Before the patient's abdomen was prepped, the surgeon put a stethoscope on the chest and heard no breath sounds on one side. This patient had a tension pneumothorax where there was marked pull on the diaphragm and on the pleura resulting in board-like rigidity of the abdomen. This sequence of events in spontaneous pneumothorax is unusual, but where there is a spontaneous pneumothorax with enough pull on a pleural adhesion, the diaphragm, or the pleura, or the presence of considerable bleeding from tearing a pleural adhesion, one may encounter board-like rigidity of the abdomen.

The visceral pleural is virtually insensitive. The nerve supply of the parietal pleura is only slight, but the loose connective tissue immediately beneath the pleura is rich in nerve supply, blood supply, and lymphatics. Thus, pleural irritation of a very brief period promptly results in severe symptoms.

Conclusion

In conclusion, the diagnostician who suspects abdominal catastrophe must not only be mindful of the quality of the patient's respiration and other pulmonary symptoms but he should also make use of that ancient instrument, the stethoscope.



Acute Uropathies With Abdominal Symptomatology*

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Obstructive, vascular, hemorrhagic and other acute uropathies commonly produce abdominal symptoms.

ABDOMINAL symptoms commonly accompany urinary tract disease. This is readily explained by the common innervation of the abdominal viscera, kidneys, and proximal ureters through the celiac ganglia. The distal ureters, urinary bladder, and sex organs derive their autonomic innervation from the sacral cord via the sacral plexus. The exception is the sympathetic nerve supply to the testes, an intraabdominal organ in utero, which originates in the celiac plexus and is mediated by the spermatic plexus. This is the mechanism of abdominal pain in lesions of the testes.

Considering only uropathies which are characterized by abrupt, rigorous abdominal complaints, we have obstructive, vascular, and, occasionally, inflammatory lesions. Our concern in any case is to localize the disease process to the urinary tract after which urological diagnostic evaluation confirms the diagnosis.

Obstructive Uropathies

Obstructive uropathies frequently cause abdominal pain. Renal colic, most often the result of calculus obstruction, is sudden in onset and characteristically an undulating severe pain of intolerable intensity. The pain originates in the costovertebral angle and radiates along the course of the ureter, producing pain in the groin and/or scrotum or labium. Proximal obstructions typically produce pain in the flank, abdomen, and testicle while distal ureteral obstruction produces somatic reference to the external genitalia and inner aspect of the thigh. Hyperesthesia is present in the regions of somatic pain reference and manipulation of these areas accentuates the discomfort. Subjectively, renal colic is described as a sharp, stabbing pain and causes the patient to move ceaselessly in an attempt to find a position of comfort. This contrasts sharply with the presence of peritoneal irritation which is aggravated by any motion and causes the patient to lie consciously motionless.

When pain is severe, the patient appears cold and clammy and often has a rapid, weak pulse. Nausea and vomiting occur with obstruction of any hollow viscus and the urinary tract is not excepted. When reflex ileus occurs, this complex of signs and symptoms may easily be confused with an acute abdomen.

The diagnosis of renal colic is suggested by the history and can usually be confirmed by the physical, laboratory, and roentgenological findings. Pain is elicited by gentle percussion of the costovertebral angle and palpation of the offended kidney. Stimulation of the dermatomes of pain reference exaggerates the patient's complaints. Muscle guarding and rigidity are present over the involved kidney, but there is no sign of peritoneal irritation. Tenderness is not elicited in the right upper quadrant as in gallbladder disease nor in the region of McBurney's point as in appendicitis. Leukocytosis is present in some cases but less marked than in inflammatory diseases of the abdomen. Examination of the urine will show microscopic

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or gross hematuria in at least 80% of cases due to ureteral calculi and in virtually all cases if obstruction is not complete. Roentgenographic examination is the most important and valuable procedure in establishing the etiology of renal colic. Calculi are demonstrable in 95% of the cases on an abdominal scout film. Obstructions due to nonopaque calculi and noncalculous disorders are demonstrated by excretory or retrograde urography. The presence of renal colic without a demonstrable calculus on an abdominal scout film necessitates urological survey.

Renal Vascular Disorders

Renal vascular disorders are a far less common cause of abdominal pain but, by their very nature, require prompt recognition if therapy is to be successful. Arteriosclerotic intimal degeneration is the most common renal vascular lesion. Parenchymal destruction frequently results from progressive arterial occlusion but is symptomatic in less than 30% of the cases. Acute obstruction is characterized by sudden, severe, nonradiating, non-paroxysmal flank pain. When followed by an abrupt onset or acceleration of hypertension, occlusion of a segmental artery should be suspected. Recognition of this entity is important, not because the immediate process can be altered but because subsequent resolution of the hypertension may be accomplished by nephrectomy.

Renal infarction may result from embolic obstruction of the main or segmental renal arteries. Emboli usually originate in the heart in the presence of auricular fibrillation or from mural thrombi following coronary occlusion. Severe persistent flank pain follows partial or complete renal infarction. Associated with pain may be nausea, vomiting, shock, generalized collapse, and, very soon, hematuria. Hypertension is absent in complete renal artery occlusion but occurs in partial infarction. Excretory urograms fail to visualize the involved kidney, but retrograde urography will demonstrate a normal collecting system. The kidney is not enlarged nor palpable. In short, renal embolic infarction should be suspected when sudden flank pain, hematuria, and systemic manifestations develop in a person subject to embolic phenomenon, particularly auricular fibrillation, and the diagnosis can be confirmed by excretory and retrograde urographic studies.

Venous infarction presents a somewhat different picture. It occurs as an extension of a vena caval thrombus or as a complication of ileocolitis and dehydration. It is most commonly seen in children and has been found in newborns. Clinically, flank pain is accompanied by marked tenderness and an expanding mass. Hematuria, pyuria, fever, sepsis, and shock soon ensue as the patient's condition deteriorates rapidly. A rapid demise can be averted only by a prompt nephrectomy.

Other Causes of Pain

A variety of hemorrhagic conditions produce flank and abdominal pain of consequence. Hemorrhage into renal cysts or tumors produce capsular distension and pain similar to renal colic. Retroperitoneal bleeding from rupture of kidney tumors or renal artery aneurysms causes pain, shock, and an expanding flank mass. Tumors may be demonstrated by urography but aortography or exploration is necessary to demonstrate an uncalcified aneurysm, the type which is subject to rupture. Management is dictated by the gravity of the illness, with immediate surgical intervention often necessary.

Inflammatory lesions of the urinary tract resulting in sudden, severe pain are not common. However, infection superimposed upon strictures of the ureter or ureteropelvic junction may produce complete obstruction and colic. Pyuria, leukocytosis, and a febrile response should identify these as infectious processes.

Summary

In summary, urinary tract disorders capable of producing sudden severe abdominal distress have been discussed briefly.

Bone Marrow Examination

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Marrow aspiration is not without its risks; the distinct indications are listed and should be adhered to when considering marrow study. Historical and practical viewpoints are discussed.

Historical Notes

STUDY of aspirated bone marrow has risen from its infancy in 1909 to a prominent place in medical diagnosis today. The very early workers obtained marrow by trephining. However, most of those after 1909 experimented with various sites and with different types of puncture instruments. Dental drills, lumbar puncture needles with and without modifications, Meibomian cyst scoops and special aspiration needles such as the Turkel and Illinois type have all been proposed.

There are various methods of studying the bone marrow aspirate. The direct smear has been used longer and is more popular than any other method. It combines simplicity with convenience and is useful to diagnose most hematologic abnormalities. Such preparations do have distinct disadvantages. For example, one cannot usually accurately diagnose cellularity, the presence of granulomas, malignant lymphomas, thrombotic thrombocytopenic purpura, myelofibrosis and many other conditions with smear study alone.

To overcome some of the problems just noted, other techniques in preparation have been proposed to glean more knowledge from marrow aspirate. Most methods have been directed toward ways of preparing histologic sections. Investigators have either utilized clotting or dilution followed by concentration techniques. With clotting methods, aspirate is simply allowed to clot and is then fixed. Some modifications using partial absorption of blood by filter paper, paper towels, etc. have been utilized. Sections prepared in this manner are usually contaminated with blood. Therefore, other methods to concentrate marrow particles (units) were proposed, all principally using dilution of the aspirate with subsequent separation and aggregation of the units. Such measures are more satisfactory than clotting procedures.

Some have not only prepared direct smears and sections but have also determined volumetric readings, made concentrated and touch smears. Volumetric readings demonstrate from above downward: fat, plasma, myeloid-erythroid layer and red cells. Suffice it to say that hypercellular marrows have a large myeloid-erythroid layer and vice versa for those that are hypocellular. The fat layer has an inverse relationship to the myeloid-erythroid layer.

Indications for Marrow Aspiration

Bone marrow aspiration is not a procedure that should be ordered as a routine test. The procedure is not difficult to perform but it is not without its risks. In addition, when marrow is properly aspirated by means of a closed suction system, it is almost routinely painful—a sensation described as being "pulled inside out."

Certain indications for marrow study are obvious. When a primary or secondary hematopoietic disease is present or suspected, marrow study may be of great value. On the other

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hand, when obvious peripheral blood disease exists such as typical acute or chronic leukemia, the value of marrow examination is questionable unless it be for didactic interest or for study of the effects of newer drugs.

Secondly, marrow study is indicated when a diagnosis cannot be established in the presence of the following clinical or laboratory findings: undetermined fever, lymphadenopathy, hepatomegaly, splenomegaly, purpura, indeterminate thoracic lesions, bone lesions, skin lesions, elevated sedimentation rate, anemia, leukopenia, lymphocytosis, monocytosis, thrombocytopenia, immature cells, normoblasts, rouleaux, and leukocytosis.

Before a bone marrow study is ordered a peripheral blood smear should be carefully evaluated. It is rare that significant marrow pathology is found in the presence of peripheral blood that is "within normal limits."

Site of Aspiration

Bone marrow is one of the major organs in the body, amounting to 5% of body weight. Despite its overall bulk, it is distributed with regular irregularity. It is most commonly located in the vertebral bodies, sternum, ribs, pelvic crest and at the ends of long bones.

For routine studies the sternum at the level of the second interspace is selected. It is not only of good cellularity but is by far the most easily accessible site. The iliac crest is harder to approach and contains a thick, often unyielding cortex. With gentleness, persuasion and a sharp aspiration needle (preferably Turkel type) the sternum offers no problems to an experienced operator.

When metastatic carcinoma, or other lesions are suspected, the site of clinical or roentgenologic involvement is selected. Similarly, in instances of suspected metastatic prostatic carcinoma, the pelvis is chosen.

Children present a somewhat different problem. The sternum is not selected in those less than 6 months of age or less than a year old if of small size. Instead, the medial aspect of the tibia just below the tubercle is selected. I have done numerous sternal punctures in children over one year of age although it may be very difficult on a squirming, squealing youngster, using local anesthesia. Light general anesthesia is preferable. The entire procedure rarely takes more than a few minutes.

Technique Used for Studying Marrow Aspirate

After local anesthesia, the cortical layer of the sternum is perforated at the second intercostal space with a Turkel needle. Two ml. of bone marrow are aspirated by hard, rapid suction, using a 10 ml. syringe. The aspirated specimen is emptied into a small paraffin-coated glass vial containing 8 drops of anticoagulant solution consisting of 10% disodium ethylenediaminetetraacetic acid (EDTA) in normal saline. The vial is rotated gently to mix its contents. The plunger of the syringe is then rotated inside the jacket to break up remaining adherent bone marrow particles. This material, rich in cells, is squirted onto slides (and/or coverslips) and smeared for subsequent cytologic study. A slide is immediately stained to determine the relative cellularity of the specimen. If cellularity is inadequate, concentrated spreads are prepared from the buffy coat following centrifugation in a Wintrobe or micro-hematocrit tube at 2000 rpm for 5 minutes. In cases of agranulocytosis or severe hypoplasias, concentrated smears are very helpful.

The remaining marrow aspirate is then transferred from the vial to a Petri dish and mixed gently with about 20 ml. of 10% formalin in normal saline. After standing a short while, the contents are poured into a 75 mm. funnel lined with 2 layers of lens paper or 1 layer of coffee filter paper.* If particles stick to the sides of the paper, they are washed toward the center with a Wintrobe hematocrit pipette. It is usually necessary to re-wash the Petri dish with neutralized formalin to salvage units that have been left behind. This material is also transferred to the funnel and processed as before. Eventually, one will have a small centrally placed ball of units. The lens paper with the units is gently lifted out of the funnel and laid on a flat surface and the sides trimmed. The paper is folded and placed in a tissue capsule. It is then processed as any other surgical tissue and is stained with hematoxylin and eosin. For embedding it is easier to open the folded lens paper, containing the small collection of marrow units on a hot plate set at 60° C. The material is then carefully transferred on a small spatula to paraffin. Ordinarily the mass of marrow particles will remain aggregated.

**Filtrator Coffee Apparatus Co., 135 West 25th St., New York 1, N. Y.*

Value of Marrow Aspirate

1. *The Aspirate as a Whole*—Marrow may be aspirated and stored for re-use following procedures such as total body perfusion with massive doses of nitrogen mustard or other anti-tumor agents. For such use one can aspirate up to 600 ml. of marrow using as many as 30 puncture sites. It can then be stored for 24 hours at 4° C. in paraffin lined bottles with heparin as anticoagulant. Following reinfusion of bone marrow in such patients normal marrow activity can be observed within two weeks. With present techniques, such procedures are doomed to fail if marrow is contaminated with tumor cells. Thus a preperfusion marrow survey by aspiration studies is essential. The possibility of separating myeloid-erythroid elements from tumor cells in the aspirate by differential centrifugation exists, but it is not yet practicable.

Some have advocated storing ones own marrow in a deep frozen state for possible future use such as following massive total body irradiation in an atomic war.

Bone marrow may also be used for purposes of culture. It is best to make an individual aseptic puncture for such a purpose. Routine marrow study is done separately. While proponents of bone marrow culture are quite enthusiastic regarding the value of this procedure, in my opinion it has proven to be disappointing. For that reason I do not recommend it be done unless other means have been exhausted.

2. *The Marrow Smear*—Among the conditions which may be diagnosed with certainty are multiple myeloma, lipid storage diseases, metastatic carcinoma, lupus erythematosis, megaloblastic anemias, thrombocytopenic purpura, agranulocytosis and leukemia (especially aleukemic forms in children). Conditions in which marrow study is of only confirmatory significance include anemias, leukemias, and certain tropical diseases. Not all of the listed conditions can be diagnosed with ease by marrow smear. For example, it is often difficult to separate a well differentiated myeloma from a severe plasma cell reaction. Marrow sections are necessary to observe the nodular pattern and the perivascular relationships respectively. Once again, marrow smears often do not accurately reflect cellularity and cannot be depended on to reveal certain lesions; for this reason histologic sections of marrow aspirate are of value.

3. *Histologic Sections* —Histologic sections of bone marrow are of great importance in diagnosing many space occupying lesions and may act as a referee to confirm or deny findings listed above. For example, utilizing sections, the histologic structure of a metastatic neoplasm may become very evident and the site of origin more clearly indicated.

In addition, paraffin sections are, for all practical purposes, necessary for observation of granulomas seen in various states such as tuberculosis, brucellosis, deep fungi, herpes zoster and infectious mononucleosis. Similarly, such sections are needed to diagnose malignant lymphomas. The literature stresses the rarity with which the latter are recognized by marrow smear but recent experience has demonstrated the ease by which lymphomas can be diagnosed by paraffin marrow sections.

Other states such as myelofibrosis and thrombotic thrombocytopenic purpura can be more accurately diagnosed by such means.

Summary

The study of bone marrow has been discussed both from the historical and practical viewpoint. There are distinct indications for marrow aspiration; these have been listed and should be adhered to when considering marrow study. A normocytic, normochromic blood picture is seldom associated with medullary pathology. Marrow aspiration is not without its risks and should not be considered a routine procedure. Many hematologic conditions can be diagnosed by blood smear alone, some necessitate marrow smears and others require paraffin sections of the aspirate. In general, the most accurate studies consider all three methods.

Report on the Kentucky Commission on Alcoholism*

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Modern knowledge of alcoholism and a rational plan for prevention are outlined in this report of encouraging progress.

THE history of the world abounds in incidences of excessive drinking of beverage alcohol and the problems created by drunkenness. In the book of Genesis, the record of Noah's drunkenness, his indignation at his son's discovery of his condition, and the family rift as a result, is a forerunner of a type of story repeated thousands of times in the intervening years. In the book of Deuteronomy is found the first record of drunkenness being classified as a crime, punishable by stoning to death. As early as 2250 B.C. one of the kings of Babylon decreed price fixing and control of the sale of wine. Within a period of about 2000 years, between the middle of the Chan dynasty (1134-256 B.C.) and the reign of the fourth emperor of the Yuan dynasty (about 1312 A.D.), laws against the manufacture, sale and consumption of wine were established and repealed no fewer than 41 times in China. Early in the first century a Roman Emperor ordered half the vineyards destroyed and forbade the planting of more.

Prohibitory Measures

The early history of the United States is filled with references to problem drinking. Governor William Bradford of Plymouth complained of drunkenness on the part of some of his people. In 1734 the English Parliament, at the instigation of Governor James Oglethorpe, passed an act "prohibiting the importation of rum and brandies" into Georgia. The end result of this law was wholesale rum running, the establishment of moonshine stills, and under-cover dispensing in cabins and back rooms of business houses. The violations were so flagrant that after seven years the law was repealed. In 1851 Maine became "dry" by law. In 1852 Minnesota, Rhode Island, Massachusetts and Vermont adopted prohibition. From 1852 through 1855, Michigan, Connecticut, Indiana, Delaware, Pennsylvania, New York, New Hampshire and Iowa went dry. These prohibitory laws did not last but are indicative of the only known approach to a recognized problem.

In 1879 Miss Frances Willard was elected president of the Woman's Christian Temperance Union. In 1895 the Anti-Saloon League of America was organized, and shortly thereafter Mr. Wayne B. Wheeler became counsel and superintendent. The militant efforts of these two outstanding personalities were largely instrumental in the growth and power of the respective organizations. The combined efforts of these organizations over a period of forty years eventually resulted in the eighteenth amendment to the Constitution, prohibiting the manufacture and sale of alcoholic beverages in the United States. The prohibition era lasted for fourteen years; the eighteenth amendment was repealed in 1934.

Other Approaches

From earliest written history the problem of alcoholism has been recognized as serious; yet not until 1935 has there been any approach

**The Kentucky Commission on Alcoholism has been dissolved by Governor Combs, but its members are still acting in an advisory capacity. This paper was presented before the Kentucky Psychiatric Association at the 1960 Annual Meeting of the KSMA, September 22, 1960.*

other than punishment as a crime or prohibition of manufacture and sale of beverage alcohol. In 1935 two widely separated events occurred which have had a profound influence on the thinking of the world regarding the uses and effects of intoxicants. Dr. Edward M. Jellinek, already a renowned scholar, started a study of alcoholism as a problem in sociology. His interest aroused, he drafted a physiologist, then a statistician; these early efforts resulted in the organization of the Yale Center of Alcohol Studies. From this project has come more real, authentic information about alcoholism than had been known prior to 1935. As a result of the Yale Center's efforts more than thirty states now have tax-supported programs devoted to the rehabilitation of the alcoholic, research as to cause, and education of the public to the seriousness of the illness. The numerous scientific approaches, the research programs in the field, are a direct result of the Yale Center's activity.

That same year two hopeless drunks, trying to achieve sobriety, originated a program of rehabilitation from a layman's viewpoint. With no professional background and no scientific training they evolved a program of positive action which resulted in sustained sobriety. From these two has grown an organization, estimated at two hundred thousand, of men and women who have apparently conquered their personal alcoholism. Alcoholics Anonymous now has local groups in every state and in all the provinces in Canada.

The Kentucky Commission

The Kentucky Commission on Alcoholism was established by act of legislature at the 1956 session. The Commission was appointed by the Governor, but no funds were appropriated for operation. A contribution of $500 paid for some stationery and some incidental expenses. This contribution was the only money available in 1956.

In August 1957 the Commission employed an executive director on a theoretical salary to be paid when and if funds became available. The only money available in 1957 was $1,000 contribution from a member of the Commission, which was used to pay for scholarships to the Yale Summer School of Alcohol Studies. These scholarships were awarded to staff members of the Department of Mental Health who were active in the treatment program for alcoholics conducted by that Department.

No other funds were available until July 1, 1958.

Through the cooperation of the Department of Public Relations a news service dealing with various phases of alcoholism was inaugurated January 30, 1958. This series has gone to 180 Kentucky newspapers each week since that date. A number of the newspapers have published all of these articles; others have published some of them.

During the first eleven months of operation, Aug. 1957 to July 1958, speaking engagements before luncheon and civic clubs, explaining the extent of the problem and the aims and purposes of the Commission, were filled by the executive director in Princeton, Paducah, Madisonville, Owensboro, Richmond, London, Ashland, Lexington, Danville, Louisville, Frankfort, Georgetown, LaGrange and Eddyville.

Inquiries from mothers, wives, families and friends of alcoholics, directly resulting from the newspaper releases, came from all parts of the Commonwealth. These inquiries were all answered and referrals made to the nearest source of help.

The Commission has examined and studied the procedures of twenty agencies in other states already engaged in tax-supported alcoholism programs, and has tried to pick the best features of each for use by the Kentucky Commission.

This is a brief resume of what was done without funds.

The 1958 session of the legislature appropriated $25,000 per annum for the next biennium to operate the Commission. These funds became available July 1, 1958. An office was opened at Frankfort on that date.

After studying the operations of various agencies in other states, the Kentucky Commission realized there is no pattern of operation. Amounts appropriated varied from $15,000 per annum in Arkansas to $704,800 per annum in California.

Programs varied from small educational efforts to large treatment projects, research, fully staffed clinics and welfare facilities.

Conclusions from Study

After thorough study and consultation, the

Kentucky Commission arrived at the following conclusions:

1. That within the framework of our state government there already existed facilities and skills potentially able to help alcoholics. That it would be a waste of time and money to establish new resources when the real need was to get the existing facilities to adapt their skills and resources to the needs of alcoholics.

2. That this goal could be reached only through a long-range program of education. This is not a spectacular approach but, for the long pull, is more sensible and economical, and is better government than duplicating existing facilities.

3. That this program of education, the biggest problem, divided roughly into four parts:
a. Most important is education of the general public on the illness of alcoholism, to attempt to remove some of the stigma, to create an understanding atmosphere conducive to the alcoholic's seeking available help.
b. Educating professional people, particularly physicians, nurses and hospital administrators, to accept alcoholic patients on the same basis as individuals suffering from other physical, emotional and social illnesses.
c. Education of the problem drinker. To create a widespread knowledge of the symptoms of alcoholism in the early stages. To convince the problem drinker that he is sick, that alcoholism is a treatable illness and to let him know of the available facilities for help.
d. Education about alcohol problems at the school level. We feel that alcoholism is a part of alcohol education but not a major part, so far as school-age children are concerned. Education at the school level is solely the province of teachers. This Commission's role is to bring the problem to the attention of public educators and to assist them in every possible way in originating a program which will be satisfactory to teachers, parents and students.

Progress Made

Using the existing facilities and skills within the state government we have made much progress. Dr. H. L. McPheeters, Commissioner of Mental Health, authorized the segregation of alcoholic patients committed to Western State Hospital in a separate ward. This separation from patients suffering from basic mental illness had the immediate effect of improving the treatment atmosphere tremendously. Using modern treatment methods, this ward has had marked success with a number of alcoholics who had been characterized as hopeless. There have been a number of problems in administration, control and change of personnel. Everyone is still working toward modern treatment. In recent months renewed interest seems to be in evidence. This has been done without the addition of a single person to the staff of the hospital. Some additional personnel would greatly enhance the effectiveness of this facility. Appropriation of a few thousand dollars to the Department of Mental Health would allow this department to open another treatment facility at Kentucky State Hospital. In the opinion of the Kentucky Commission on Alcoholism, these two wards can accomplish as much, in the realm of treatment, as is being accomplished in some other states with separate hospitals with annual appropriations in excess of $200,000 each.

Through cooperation of the Department of Mental Health a special type of commitment, the Alcoholic Commitment Law, has been established to admit alcoholic persons to a state mental hospital. The law provides for both voluntary and involuntary admissions, and in both cases an application is filed with either the circuit court or the county court clerk.

In 1958 the Commission sponsored the attendance of the chaplains from Kentucky State Hospital and Eastern State Hospital and a psychiatric aide from Western State Hospital at the Yale Summer School of Alcohol Studies. The following year the Commission used part of its appropriated funds to send two nurses from Western State Hospital and one nurse and the clinical director of Kentucky State Hospital to this School. In 1960 we sent a doctor from Kentucky State Hospital, a coordinator for the Alcoholic Ward at Kentucky State Hospital, a Health Educator with the Kentucky Department of Health, a nurse from Western State Hospital and the secretary from our Commission office to the Yale School. This expenditure has paid large dividends in better understanding by the hospital staff, increased interest in the solution of vexing problems and fuller cooperation with the Alcoholism Commission in its efforts to establish a well-rounded, long range

program.

In our program for education of the general public the weekly newspaper articles on phases of the alcoholic illness have been continued. Public interest generated by these releases has exceeded all expectation. A questionnaire sent to all the newspapers in January, 1959, brought an unexpected response. Of 180 papers queried two thought the releases valueless; seventy-two thought they were of fine educational value, approved their content as factual and newsworthy and asked that they be continued. Inquiries from readers continue, and more than 3,500 pieces of educational literature, dealing with specific phases of the alcohol problem, have been distributed.

Five Kentucky industries have become interested in establishing educational programs within their own business organizations. In several instances this has led to early detection of problem employees and corrective measures were inaugurated. Using the already existing facilities and skills in the Department of Public Relations of Kentucky made this possible.

A representative of the Commission on Alcoholism has addressed annual meetings of the Kentucky Welfare Association, the Kentucky Congress of Parents and Teachers, and has conducted workshops on the problem at the state meetings of these organizations.

Film and Booklet Available

A film, "To Your Health," an animated color movie prepared by Dr. Edward M. Jellnick of the World Health Organization, has been shown a number of times to an aggregate audience of more than 5,000 individuals. This film is available without charge to any interested organization.

A booklet, "Some Facts about Alcohol and Alcoholism," has been prepared and published by the Commission. It is now being circulated. Requests for this 44-page brochure have come from physicians, clergymen, judges, law enforcement officers, teachers, members of Alcoholics Anonymous, welfare workers, students and many individuals seeking further information about alcoholism. Five thousand of these booklets were originally published, and present demand indicates a reprint will be necessary. We are sending this and other literature to all physicians, libraries, schools and selected organizations in Kentucky.

We are doing much to further the alcoholism education of professional people in the state. Underwritten by the Kentucky Commission on Alcoholism, Leonard Morgan, Supervising Chaplain at Eastern State Hospital (Mr. Morgan completed the Yale Summer School of Alcohol Studies in 1958 on a scholarship furnished by the Commission), conducted a three-day seminar for clergymen at Eastern State Hospital, Lexington, in January 1959. Authorities in the field, including Dr. Selden Bacon, Director of Yale University Center of Alcohol Studies, staffed this seminar. Representatives of seventeen different faiths attended. This will be repeated next January with the Commission underwriting about two thirds of the cost.

At the scientific assembly of the Kentucky Academy of General Practice one hour was devoted to the subject of alcoholism. Dr. Donald Brodie of Indianapolis conducted this session, at the instigation of this Commission. So much interest was aroused that the Commission circulated a questionnaire to 482 physicians, members of the Kentucky Academy of General Practice, asking opinions on a separate education seminar, limited to physicians, on alcohol and alcoholism. 172 doctors indicated a desire to attend such a meeting. This was held at the Brown Hotel, Louisville, November 5, 1959, underwritten by this Commission and cosponsored by the University of Louisville School of Medicine, the Kentucky Academy of General Practice, the Louisville Academy of General Practice and the Kentucky Psychiatric Association. The American Academy of General Practice granted seven credit hours to members who attended. The seminar was staffed by Dr. Marvin Block, Chairman of the Committee on Alcoholism for the American Medical Association; Dr. Thomas G. Scharff, Department of Pharmacology, University of Louisville School of Medicine; Dr. John A. Lewis, Chief Mental Health Service, U.S. Public Health Service; Dr. Roger J. Williams, Director of Clayton Institute Bio-Chemical Research and Professor of Chemistry at the University of Texas; Dr. Edward J. Delehanty, Chairman of the Colorado Commission on Alcoholism; and Dr. Louis Foltz, Chairman of the Kentucky Commission on Alcoholism.

The Commission planned to hold similar

seminars in 1960 for industry, nurses and hospital staff, and public school teachers. Unfortunately, the death of our executive secretary has delayed these, but our plans have not changed.

Education a Primary Concern

Education of the problem drinker is one of our primary concerns. The Yale Center of Alcohol Studies, through a massive and factual research program, developed "The Profile of a Problem Drinker." This Profile traces the progress of symptoms from pre-alcoholic stage to early stages and later stages of alcoholism. We have published this in a leaflet and 2,000 copies have been distributed in Kentucky. Many of these copies have gone to individuals on request, some to families or friends of alcoholics and a number to industrial organizations. Talking from a large chart, representatives of the Commission, graduates of the Yale Summer School of Alcohol Studies, have explained these symptoms to a large number of groups, an aggregate audience of 3,500.

Some definite cases have been brought to light and corrective measures inaugurated. It is believed that others have been benefited, but we have no proof of this.

The "Profile" is, in the opinion of the Commission, the most valuable tool so far developed. It will be continously used and this phase expanded as it becomes more widely understood.

We feel that education concerning alcohol at the school level is important. Kentucky has a law, No. 158270, requiring mandatory instruction on alcoholism in the public schools. Due to the controversial nature of this subject it has been confused as a "wet" or "dry" issue, and most teachers have either ignored it or confined their efforts to a meaningless gesture once or twice a year.

In an effort to work out a program of instruction which would be acceptable to teachers, parents, "wets" and "drys," the Commission has consulted with educators, parents and teachers, state administrators and school administrators. It has furnished a printed dissertation on the subject *"What Shall We Teach About Alcohol,"* by Professor Raymond McCarthy of Yale University, to 700 chairmen of Kentucky P.-T.A. groups.

Contacts have been made with school superintendents and two state education departments which have made some progress in this field (Oregon and North Dakota). The Louisville Public School System has become interested and active. Mr. Thomas B. Godfrey, Supervisor of Health and Physical Education Department, Louisville Public Schools, has prepared and circulated to teachers in the Louisville Schools a manual *"Suggested Materials For Teaching Alcohol and Narcotics in Secondary Schools."* This is an excellent work. The Louisville Department has inaugurated a teaching program, which is a real "break through." This program will be refined with experience. A truly factual course of instruction is under way. Acceptance by educators of this responsibility is gradually growing.

Evidences of Interest

At the invitation of Rev. John Ramsey, Professor of Sociology at Villa Madonna College, the Commission sent a representative to speak to three classes at this school. The interest shown by these students was amazing. The discussion period after the lectures disclosed a genuine seeking after knowledge. Professor Ramsey attended the Yale Summer School of Alcohol Studies in 1959 as a direct result of this effort. His influence in the parochial schools has resulted in requests to the Commission for speakers to appear at several other Catholic schools.

The Department of Psychology at Centre College, Danville, booked a speaker from this Commission for a November 1959 appearance. The superintendent of schools at Ashland booked a representative of the Commission for a lecture to students and a consultation with teachers in that city.

These evidences of interest and progress at high school and university levels are most gratifying. It demonstrates that facilities are already available and that they are willing and anxious to put their skills to use.

The Commission is beginning to expand its public education program through the cooperation of the Division of Public Health Education, Kentucky State Health Department. A health educator, recently employed by the Commission, is attached to the Health Department staff. She has responsibility for organizing and carrying out alcoholism education pro-

grams throughout the state and for coordinating the work of other health educators, all of whom will spend part of their time in this program. In this way the public education program will have wider spread than has been possible before. The education program will be research oriented, its immediate aim to discover how best to reach and teach various socio-economic groups about so sensitive a subject as alcohol and alcoholism. The program's present focus is the school population and those groups which most influence the growing child, the parents and the church. A pilot study is being planned now which we believe will give a firm basis for a statewide educational effort aimed at these and other groups.

Summary

The Kentucky Commission on Alcoholism is a new agency pioneering in a field little understood for 4,000 years. There is no set pattern, no guide to be followed.

The past decade has produced an astonishing number of facts entirely contrary to opinions held for ages. These facts must be made available to Kentucky citizens in an effort to replace prejudice and misinformation.

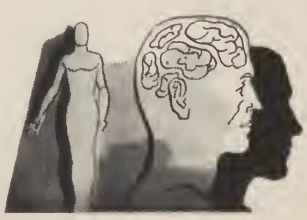
Authenticated figures show every individual alcoholic costs the state approximately $520 per annum in jail and court costs, welfare costs, lost wages, bad debts and hospital care. There are approximately 67,000 alcoholics in Kentucky. If only 2,000 are rehabilitated, a net saving in excess of $1,000,000 is not only possible but well within the bounds of probability. The financial saving is important, but far greater is the saving in broken homes, delinquent children and salvaged lives.

The first 26 months of operation demonstrates that available skills and facilities exist. Experience shows that there are people willing to accept responsibility in their particular fields, when the need is brought to their attention and proper support and resources are provided. Examples of this are noted in the Departments of Public Relations, Public Health, Mental Health and Education.

The Kentucky Commission on Alcoholism conceives its function to be that of a coordinating agency offering resources, referrals, materials and counsel to existing agencies capable of completing a well-rounded program. It has used the facilities and skills of a lay organization, Alcoholics Anonymous, to great advantage and without cost. Individual members of this group have been most helpful.

We do not expect to perform miracles. It is, of necessity, a long-range program. Our budget request is based on a minimum of overhead, patronage and frills, a maximum of economy, and the dedicated efforts of experienced men and women.

It is hoped and believed that the Kentucky Commission on Alcoholism has made a sound beginning and that it has a high potential for good in the future.



Placenta Increta

Ali T. Arban, M.D., and George G. Greene, M.D.*

Lexington, Ky.

A case involving placenta increnta is presented and discussed. A theory is advanced by the authors regarding the initiating factor in the toxemia of pregnancy.

PLACENTA increta is an obstetrico-pathological entity which is clinically recognized by the absence of a cleavage line between placenta and uterine wall on attempted manual removal of a retained placenta after spontaneous efforts at expression have failed.

It is described as a deep penetration of trophoblasts into the myometrium with complete absence of decidua basalis.[2] If this myometrial invasion by placental elements is shallow, it is known as placenta accreta vera. Placenta percreta is the term applied to the invasion of perimetrium by chorionic villi, eventually perforating the uterus. This classification of placenta accreta depends on depth on involvement. It is also divided into three types as total, partial, and focal.

Concurrent placenta previa and placenta accreta, though rare, is the most difficult to deal with because lower segment atonicity causes dangerous postpartum bleeding.

Due to differences in definitions and failure to report, the actual occurrence of placenta increta is unknown. As far as we can ascertain, approximately 300 cases of placenta accreta have been reported.[3, 5]

Disruption of myometrial sinusoids which are normally seen in dicidua and insufficiency in local thrombosis due to absence of thromboplastin carrying decidua are the leading causes of disastrous uterine bleeding which usually occurs during vigorous manual attempts to remove the inseparably attached placenta.[2]

The treatment of choice is supracervical hysterectomy. Conservative treatment should be preferred only to preserve fertility. There have been reports of successful pregnancies following expectant treatment.[4]

The following case is reported for statistical value.

Case Report

Mrs. O. F., a 19-year-old white female, gravida II, para I, was admitted to Central Baptist Hospital on 8/19/1959 at 11:30 p.m.

According to the information from the accompanying nurse, she went into premature labor at 1:00 p.m., and delivered, at 6:30 p.m., a stillborn female infant; then went into shock during the vigorous attempts to deliver the placenta by manual detachment. The cause of fetal loss was linked to cord strangulation. Restoration of blood loss was obtained by quick transfusion. She was then transferred by ambulance from Owenton, Ky. to Lexington (68 miles distant). Enroute she had cramps and hemorrhaged profusely. At the time of admission to the above hospital, she knew nothing of the recent delivery.

Upon arrival, she was in shock, with a blood pressure of 60/40 and an impalpable pulse. Bleeding was minimal. There was a midline mass, arising from the false pelvis and extending to the umbilicus, the size of a 6-months gestation.

From the Department of Obstetrics and Gynecology, Central Baptist Hospital, Lexington, Kentucky. *The authors are indebted to Dr. H. Davis Chipps for his excellent pathologic evaluation of the surgical specimen.*

During the blood replacement, the patient was taken to the delivery room were a sterile vaginal examination confirmed the standing diagnosis. The already ruptured cord was cut off. Then the patient was prepared for abdominal surgery.

On exploring the pelvis at operation, everything was as normal appearing as would be expected. There was a large puerperal uterus. A routine supracervical hysterectomy was done. Both tubes and ovaries were preserved.

Gross examination of the specimen revealed complete placental attachment to the uterine wall. The uterine cavity was filled with clotted blood. Further examination of the specimen showed why attempted manual detachment was unsuccessful. Seemingly during the attemps to deliver the placenta, the funis must have been broken. The placenta was inseparably attached to the uterine wall with no line of cleavage. At different places cotyledons were seen reaching almost to the perimetrium, invading all of the myometrium.

The patient made a satisfactory recovery from the operation and was discharged on the sixth postoperative day in good condition. She received only supportative and restorative measures.

Menstrual history: Onset of menses at age 15. Her menstrual cycle was 32 days and her periods lasted five days. Her last menstrual period occurred on Nov. 3, 1958. She had abnormal bleeding episodes on Dec. 25, 1958 and on Jan. 3, 1959.

Past history: The present pregnancy was also complicated with prevailing symptoms: high B/P, swollen face, legs, and hands, and albuminuria. She gained 20 lbs. in spite of diet and medications.

She was hospitalized for three days in June, 1959, because of her various toxic signs and symptoms. At that time there was three plus pitting edema of the ankles. Oddly enough, the urinary findings were negative. Her eye grounds were negative. She had no cerebral or visual disturbances. NPN and uric acid were normal. She was discharged showing some improvement.

The Pathological Report

Gross examination: Specimen consists of a uterus which has been amputated supracervically. It measures 11 x 13 x 13 cms and weighs approximately 600 grams. A large mass of placenta is present in the fundus which cannot be separated from the uterine wall manually.

Microscopic examination: Histological examination reveals placental tissue with some hemorrhage and necrosis with interdigitating strands extending down into the myometrium. Deep infiltration (2/3 thickness) of myometrium by chorionic villi without intervening decidua. Pathological Diagnosis: P l a c e n t a Increta.

Discussion

For many years we have been interested in the initiating factor in the toxemia of pregnancy and we had a theory[1] which we have not proven as yet experimentally. This case might have lent further evidence in the direction that we have been thinking. We know that there have been many theories advanced but none that ever have been absolutely proven so far.

We reasoned that absorption of foreign protein by the maternal blood stream produced

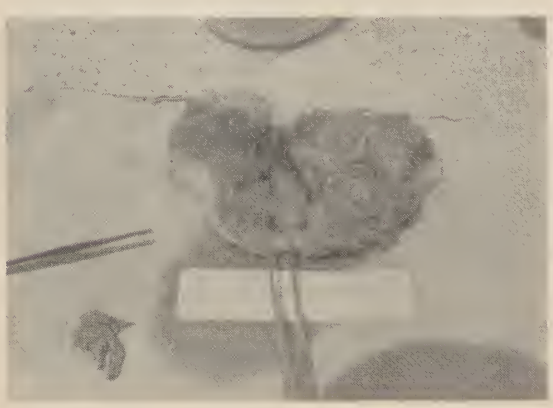


Figure 1. Gross specimen shows uterus with attached placenta inseparable throughout the entire placento-myometrial contact.

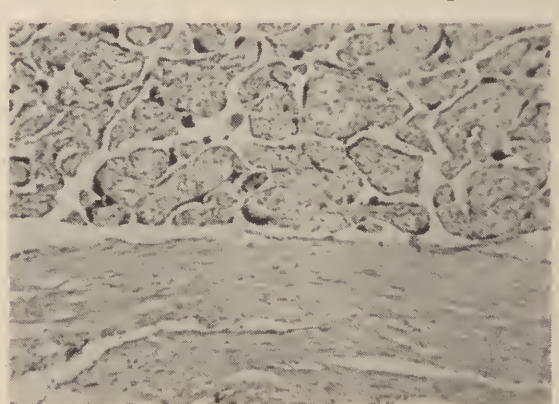


Figure 2. Muscle fibers lie directly beneath the chorionic villi without intervening decidua.

an internal anaphylactoid reaction that initiated a vaso-spasm similar to that which occurs when some form of protein is injected into a sensitized individual. We feel that since the chorionic villi are continuously bathed in the maternal blood stream they might be a source from which a foreign protein arises and is swept into the blood stream. If true, this could be the causative agent in the toxic condition which we see in these individuals.

This patient had marked toxemia which developed about the sixth month of her pregnancy for no known reason. She had a previous pregnancy without incident. Since the placenta in her second pregnancy was embedded in the uterine musculature and in turn invading maternal sinuses, this seems to support our theory.

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Manuscript Memos

Manuscripts should be submitted in duplicate to The Journal of KSMA, an original copy and one carbon, and typed with double spacing. Maximum length of an article should not exceed 4500 words; the Board of Consultants on Scientific Articles prefers that they be briefer than this when possible.

In submitting a manuscript, the author is requested to include a concise summary, not to exceed 35 words, to be used as a sub-title when the article is published in The Journal. The purpose of the summary is to create additional interest and encourage greater readership.

Footnotes and bibliographies should conform to the style of the Quarterly Cumulative Index Medicus published by the American Medical Association. This requires in the order given: name of author, title of article, name of periodical, with volume, page, month—day of month if weekly—and year. The Journal of the KSMA does not assume responsibility for the accuracy of references used with scientific articles.

All scientific material appearing in The Journal is reviewed by the Board of Consultants on Scientific Articles. The editors may use up to six illustrations, with the essayist bearing the cost of all over three one-column halftones.

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The bylaws of the Kentucky State Medical Association provide that all scientific discussions and papers read before the KSMA Annual Meeting shall be referred to the KSMA Journal for consideration for publication. The bylaws further state that the editor or the associate editor may accept or reject these papers as it appears advisable and return them to the author if not considered suitable for publication.

Please mail your scientific articles to The Journal of the Kentucky State Medical Association, 1169 Eastern Parkway, Louisville 17, Kentucky.



CASE DISCUSSIONS
From The
University of Louisville Hospitals



Louisville General Hospital*

Carcinoma In Situ In Pregnancy

E. T., a 32 year old Negro gravida 7, para 6, was admitted to the Louisville General Hospital on October 17, 1960, in the ninth week of pregnancy, for a cone biopsy of the cervix. She had been seen periodically in the outpatient clinic for five years, during which time numerous routine cervical cytological smears had been reported as negative. In September, 1960, a cervical erosion was noted on pelvic examination, and the cervical smears at that time were reported as abnormal. At this time, the patient was six weeks pregnant, the expected date of delivery was calculated to fall on May 18, 1961.

The history of past illnesses included seasonal asthma and hay fever, and a left salpingectomy and appendectomy in January, 1960, for a tubal pregnancy.

A four-quadrant punch biopsy done on September 29 showed only slight atypia. The patient was subsequently admitted for a cold conization of the cervix. This was performed on October 18. The cone specimen showed non-invasive intraepithelial carcinoma. The patient was followed in the Prenatal Clinic, where periodically repeated smears continued to show abnormal cells.

On May 13, 1961, in the thirty-ninth week of pregnancy, the patient was delivered spontaneously of a six pound living female infant after an uneventful 10 hour labor. The postpartum course was unremarkable. On July 10, seven weeks postpartum, a repeat cold conization of the cervix was done and was reported as showing "severe dysplasia." A total abdominal hysterectomy with conservation of the adnexa was carried out on July 13. The postoperative course was normal. No residual lesion was demonstrable in serial sections of the cervix.

Patient Protocol #253649

Discussion

Harold J. Kosasky, M.D., Assistant Professor of Obstetrics and Gynecology, University of Louisville School of Medicine.

This case illustrates the method of diagnosis and treatment of intraepithelial carcinoma of the cervix in pregnancy. Carcinoma *in situ* shows the histologic changes of malignancy throughout the thickness of the squamous lining, without penetration of the basement membrane. Although it usually starts in the region of the squamocolumnar junction, it may begin anywhere from the internal os to the portio vaginalis. Often its origin is multicentric, so that any treatment used must completely eradicate all potential foci.

Cellular abnormalities of the uterine cervix are common in pregnancy. Basal cell hyperplasia is present in 91 per cent of patients, atypical cytology in 16 per cent, and intraepithelial carcinoma in 1.5 per cent. This rate of carcinoma *in situ* is three times greater than that found in the general population. Most of these cervical changes regress within six to twelve weeks following delivery, unlike those seen in cervices of nonpregnant women.

The average age group of pregnant women with noninvasive cervical carcinoma is 30-35 years, with a mean of 32 years. This is five

years younger than the average age of nonpregnant women with the same lesion. Thirty per cent of the pregnant patients with this lesion are under 30 years of age. This disease is uncommon in nulliparas, and common in the lower socioeconomic groups in whom the age of first coitus and marriage is low, while sexual activity and parity are great. The probability of the carcinoma becoming invasive increases approximately 4 per cent per year up to 10 years.

Intraepithelial carcinoma is asymptomatic. The most satisfactory method of screening is the Papanicolaou smear of the posterior vaginal pool, cervix, and endocervix. Routine vaginal and cytological examination should be done at the patient's first visit as part of her physical examination. Only by so doing will the present situation be eliminated whereby nearly one-half of invasive carcinomas of the cervix are not diagnosed until delivery.

Should the smears show suspicious cells, a four-quadrant or cold cone biopsy of the cervix is indicated to exclude carcinoma. An adequate cone of tissue includes the apex at the internal os and a base of 2 cm. diameter on the portio vaginalis. In the diagnosis of non-invasive carcinoma, four-quadrant biopsy is 90 per cent accurate, while conization approaches 100 per cent accuracy.

Of the 206 diagnostic cervical conizations performed at the Louisville General Hospital since they were first begun in 1951, nine were done during pregnancy. All nine were done within the first half of pregnancy after routine smear examination of the cervix at the first antenatal visit. Intraepithelial carcinoma was diagnosed in seven, cervical dysplasia in two. Four patients carried to term uneventfully, one delivered prematurely and four aborted. All of the latter group were threatening to abort prior to their conizations. Possibly a four-quadrant biopsy would have been better in this group, although this series is too small to draw any such conclusion.

Following a diagnosis of intraepithelial carcinoma of the cervix in pregnancy, the patient should be allowed to go to term and should be delivered normally, as this patient was. Close observation with repeat cytology and necessary biopsy is carried out. At the six weeks' postpartum visit, repeat smears are taken to determine whether the cytology is once more normal, with conization if necessary to exclude carcinoma. Following conization, approximately 40-60 per cent of cervical smears will become normal and remain so, indicating no residual carcinoma. In the remainder, the smears will remain abnormal; and among these will be found four per cent of all cases of unsuspected invasive carcinoma. In our series of nine patients, one showed invasive carcinoma in the postpartum cone specimen, even though the first cone specimen taken during pregnancy showed noninvasive carcinoma.

The treatment of choice of carcinoma *in situ* in the nonpregnant woman depends on her wish to continue childbearing. Should she want more children, she is carefully followed by cervical smear examination every three months and by cone biopsies every year to ensure early diagnosis if the carcinoma should become invasive. Once childbearing is completed, noninvasive carcinoma is best treated by total hysterectomy including a wide cuff of the vagina. The adnexa are conserved in the younger woman. Theoretically, adherence to this plan should produce a cure rate of 100 per cent.

In summary, this case illustrates the method of diagnosis and management of intraepithelial carcinoma of the cervix in pregnancy, stressing: (1) routine cytological smears at the first antenatal visit; (2) four-quadrant or cone biopsy follow-up of all abnormal smears; (3) postponement of definitive therapy in pregnancy and in women wishing more children; and (4) total hysterectomy with conservation of the adnexa in the reproductive age group as the definitive treatment of choice.



What Blue Cross-Blue Shield Means To You†

J. Ed. McConnell*

BLUE Cross-Blue Shield means to you men —entering into the practice of medicine —that plans have been developed by leaders in the field of medical and hospital care to provide an orderly, positive way for people to budget in advance, on a voluntary non-profit basis, for unexpected hospital, surgical, and some medical care, and that the protection may be continued throughout life's span regardless of age or physical condition, and may be transferred from one group to another.

Blue Cross provides protection for hospital care—in varying degrees—depending on the dues the member is willing to pay. IT IS VOLUNTARY. The more he pays each month or quarter, the more protection he is entitled to. The plan is administered by a board of trustees who serve without pay as a community service, and who represent the public, the medical profession, and the hospitals.

Blue Shield was organized by doctors for the people—not for doctors—and provides indemnity allowances, with maximums, for surgical, medical and other professional services—in varying degrees—depending on the dues the member is willing to pay. IT IS VOLUNTARY. It is administered by a board of trustees made up of 75% doctors and 25% laymen who serve without pay as a community service.

These plans have problems—and neither has all the answers to prepaid care. These plans mean to you that over 800,000 people in Kentucky will have some means to help them meet their hospital and doctor costs. A total of over twenty-two million dollars was paid last year by these plans in Kentucky to doctors and hospitals for care of members—nationally, in excess of two billion dollars. Payments for services covered are made—with a minimum of red tape—direct to the doctor or hospital.

It is vital that families budget voluntarily, in advance, for health care—especially in Kentucky.

The per capita income in Kentucky is low—70% of the national average—about $1400 per year, per person. Twenty-one counties in Kentucky have a per capita income of less than $600 per year, per person. Our economy is built on time payments. Most people buy everything on time. Seventy-two per cent of the families in America have no savings or less than $500. Only about one person in ten has enough in savings to meet his hospital bill; fewer, the hospital and doctor's costs. Therefore, people must be encouraged to budget in advance.

Your profession has organized a plan controlled by doctors that if properly managed, promoted and protected can keep the economic control of American medicine in the hands of the medical profession. This is a serious responsibility—and a trust. The formation of these plans is among the most significant developments in the march of modern medicine. Without them, the benefits of medical science would move much more slowly to all groups in the population.

†Presented at Senior Day activities, March 20, 1961.

**Vice president, Blue Cross Hospital Plan, Inc., Kentucky.*

Without these plans many families would hesitate to call the doctor when needed, or enter the hospital for fear of costs. Some would be cut off entirely from adequate medical services. Without these plans many hospitals could not operate. A family with membership in a good prepayment plan is freed from much of the nagging worry of cost—always unexpected and unwelcome blows to family fortunes. Much of such costs can be budgeted like the cost of food, shelter and clothing.

Development of these plans also has helped hold down the cost to the public and improve the protection offered by commercial insurance companies. This also is important to you in the profession and to the public. Take Blue Cross-Blue Shield out of the picture and commercial rates would increase by 40% or more, and also benefits would decrease.

These plans provide means of better public relations for the p r o f e s s i o n. In Kentucky, thirty-five men are daily calling on workers, leaders in business, industry and labor—answering questions and criticisms about hospital-medical costs, and relaying important public relations problems to leaders in medicine and the hospital field. The importance of this cannot be stressed too much. You would be amazed at the questions asked and the statements made regarding doctors, hospitals and costs. These questions must be properly answered. Many people voluntarily give of their time to make the plans work—and you need allies outside of the field of medicine; organized medicine cannot win its fight alone.

Doctors, today, are threatened on many sides—state and federal programs operating on a large scale—eagerly seeking still further enlargement; domination by pressure groups, labor unions, commercial interest, rising costs, hostile public opinion. These plans may well represent one of medicine's best hopes of a self-determining profession. Blue Shield has provided your profession with an intelligently coordinated and professionally c o n t r o l l e d corporate body through which the profession and public may deal efficiently in their common interest and to their mutual benefit. You as doctors and members of the medical society will become managers of Blue Shield. This is a grave responsibility. Blue Cross-Blue Shield and commercial i n s u r a n c e create no new wealth. You as doctors must help get the important facts across to patients, other doctors, and hospital people, that unnecessary utilization, increased charges because people carry protection, manipulation of diagnoses to help people secure benefits they are not eligible for, unnecessarily extended stays in hospitals, admissions of convenience, not only increase the cost of care, they are dishonest and will bring about undesirable regulations and control—and eventually government medicine. This is important to you and the public. Through the voluntary system, we have in America the best medical care in the world.

Leaders of Blue Cross-Blue Shield, in addition to attempting to put adequate care in reach of the public, are trying to help preserve the free choice of doctors and hospitals—the voluntary practice of medicine. They are fighting for a way of life.

Should medicine in this country be socialized, it will be the death knell of what is left of our free enterprise system.

There is probably no group in America to which the concept, philosophy, and objectives of Blue Cross-Blue Shield are of more importance than to you young men entering into the medical profession. Congratulations on this great privilege and honor, and best wishes for every success.



Will It Pay To Advertise?

"THE Image of Medicine." In present day consciousness this phrase is getting great consideration. To us, the doctors, its connotations are equally as varied as it is to people generally. Why is this? It is because people's medical experiences are as unique as people are unique, and individually none are exactly the same. In a free profession, as ours is today, this is as it should be. This is also why it should be free. People should be free and independent to find the medical situation that best fits their physical and emotional needs.

Another element has entered the picture to cause a variety of impressions of the medical profession. Many people and groups outside of medicine have attempted to describe medicine's role in life and the intimate workings of the profession. Some of these have been good and factual. Some others have been shaped by the authors' purposes to give an image of medicine that will further objectives dissimilar to our own. Such efforts have at times been so effective that one can hear even doctors themselves repeating and seemingly believing it. This is not unnatural because there has been no definitive approach that continually presents medicine's position as it truly is. Consequently the many influences tend to give an image of medicine that is mosaic and not always clear.

What should we do about this? What approach will reach people in all areas and will be truly representative of us? The answer is an obvious and direct one. The doctors themselves are best equipped to tell the story collectively as they do individually everyday.

Let us digress for a moment to look at some facts of another situation. The press is a most effective force and a continuing one. Almost everyone today reads a newspaper. It is in most homes and businesses. Perhaps the majority of any particular person's current information comes from this source. To go a step further, a newspaper's existence depends on making a profit. It must do so to continue, regardless of any other concept, and this includes political and editorial policy of papers. This is a fact of life and it is directly influenced by the relationship of sound economics and a continuing existence of a paper.

The chief source of income to a publisher is from advertisement. This brings us into a common situation with the press. One of the necessities to preserve our independence is proper advertisement of our true image. Such an arrangement should have mutual appeal. Our thoughts would have wide distribution to all walks of life. There would be continuity and the image portrayed would be a clear one because it would be done by those who know us best, ourselves. It could also weld a strong alliance for us with people of the press.

This break with the past would constitute a definite departure from traditional isolationism. It would demonstrate to the press and all people that we would be supporting them in the clearest sense. It would also continually explain and clarify our profession so there could be no doubt as to our beliefs and avowed purposes. They in turn, seeing and hearing our position should not fail to become more responsive. Our image would be given without a third person theme. Our image would be a first person description from us to all people. These facts being the case, would it not in all respects "pay for us to advertise our true image."

Hoyt D. Gardner, M.D.

The Pendulum Swings Again

IT HAS been more than 150 years since Pinel and Tuke introduced moral treatment for the mentally ill, struck off their shackles and enabled them to live with more hope, hastened the recovery of sanity for some. The pendulum had swung far.

Without the availability of historical references, we might conclude that this is truly a new era in the treatment of the mentally ill and we profoundly hope so. Doctor Francis Willis, a minister turned physician treated King George the Third and reported that nine out of ten of his patients were cured of mental illness. In the second quarter of the 19th century, mental hospital superintendents vied with each other in emptying out as many patients as possible. Earlier "once insane, always insane" had been the slogan. By 1830 thc pendulum of public opinion had swung violently to the other extreme. In 1827, a report concerning an American private institution revealed a 91.3% cure compared with only 34 to 54% cures in old and celebrated English hospitals. Even in Kentucky such an enviable reputation for outstanding treatment of the mentally ill brought visitors from faraway places. Then another declinc until with the advent of thc shock therapies, the pendulum again swung in the same hopeful direction. There are many reasons to believc that the population decline in our Kentucky Mental Hospitals as reported by Doctor H. L. McPheeters, Commissioner of Mental Health is based on much more solid and promising reasons than thosc of 1830 but we must defer the pleasure of optimism remembering how venereal diseases, presumed near extinction since the advent of antibiotics, are now on the increase.

Doctor H. L. McPheeters reveals that on June 30, 1961 the end of the fiscal ycar, the resident population of the hospitals was 6,097 a decline of 541, the sharpest rccorded since the Department of Mental Health was organized in 1952.

The advantages gained by such a record achievement are numerous. The individual patient returning to his home is of first importance. The favorable effect on his family and friends is of much value. The decrease in the crowding and the additional time allowed for therapy with the remaining patients is important. Even the taxpayer can be hopeful of a decreasing burden, but as usual, the day for that is in the far distant future.

The people of Kentucky and especially the medical profession must feel grateful for the progress being made in this program. Some of the present and projected plans for the future promise to lift our state even higher in its standing among our 50 states. A decade ago Kentucky was scraping bottom in its care of the mentally ill compared with other states.

Doctor McPheeters attributes this improvement to a number of factors ticd to increased appropriations for the program. Newer treatment methods, especially the use of tranquilizing drugs, have contributed to shorter periods of hospitalization. More and better trained personnel in all areas of the hospital have made possible such gratifying changes as open wards. Intensification of efforts to place patients not needing psychiatric hospitalization into boarding, nursing and foster homes has helped to reduce the patient population considcrably.

Statistical reports are necessary for the records but the breakdown of these often reveal conditions less pleasant than desired. A statistician in 1940 projecting mental hospital populations into the future concluded that there would be an increase until 1960 then a decline. He was a prophet.

The use of tranquilizing drugs is within the grasp of all practicing physicians. Most patients

have been on these drugs without adequate results before admission to the state hospitals. Their curative effect is questionable. Many discharged patients must continue on them for a long time and under medical guidance. It is well known that many of the more seriously ill patients quit their medication and refuse to return to clinics. This means that if the patient is to receive the care he deserves, safeguards such as home visits by social workers must be made whenever he fails to report to his family physician or a clinic. This seems to be a long step in the right direction, but can enough well trained psychiatric teams be obtained? Can they provide the follow up care desirable? The New Frontier also has many idealistic plans and hopes.

Recently a psychiatrist traveling through England and western Europe visited many mental hospitals. The methods of treatment and the use of open and closed wards varied. In England, open wards were the vogue. In Switzerland patients were kept beyond not one, but two locked doors.

The Commissioner has stated that his announced policy and effort is "to restrict the hospitals to those who need them." He has stated that there will be "a concerted effort to restrict admission of those who can benefit from psychiatric hospitalization." These objectives sound reasonable but elaboration of them is indicated. Our state hospitals have been used by some as a dumping place for individuals with incurable medical diseases, behavior problems, inadequate and immature personalities and many senile but not truly psychotic. The Commissioner wishes to maintain an atmosphere of active treatment in all of the hospitals not only for the benefit of the patients but for the good morale of the personnel staffing these institutions. Nevertheless, there will need to be admitted many patients with borderline mental conditions, with mental illnesses not responsive to present methods of treatment and senile individuals whose psychotic episodes make living at home intolerable. The present program with utilization of nursing homes for the aged, foster homes for the inactive or passive psychotic patients and the out-patient clinic plans for those presumed capable of living outside the hospital promise further reduction of the patient population. Bridgehaven and, we hope, additional half way houses should add much to the program of rehabilitation. Yet there are many mentally ill people whom other psychiatrists believe will need to have the opportunity to remain for long periods in a hospital environment in order to mature and work through the resistances of their illnesses.

Despite these adverse comments reflecting the opinion of a number of physicians, the total program is considered a success and the plans for the future promise a continuation of an active attack on mental illness. If our doubts and concerns prove to be "devils on the wall" we shall be happy to see them follow the dodo bird to extinction.

In the meantime, we hope the people of our Commonwealth will continue to encourage the present and future Administrations to provide the necessary appropriations for a dynamic Mental Health program.

Arthur R. Kasey, M.D.

You are young, my son, and, as the years go by, time will change and even reverse many of your present opinions. Refrain therefore awhile from setting yourself as a judge of the highest matters.

—Plato

ORGANIZATION SECTION

KSMA Chooses Doctor Cox As President-Elect

David M. Cox, M.D., Louisville, has been chosen president-elect of the Kentucky State Medical Association. Doctor Cox's election took place at the second session of the House of Delegates, September 20, during the Annual Meeting of the KSMA in Louisville. Gaithel L. Simpson, M.D., Greenville, was installed as President of the Association and Doctor Cox's term will begin in September 1962.



David M. Cox, M.D.

Doctor Cox, a native of Nebo, in Hopkins County, graduated from the University of Louisville School of Medicine in 1924. He opened an office in Louisville in 1928 and now limits his practice to gynecology, obstetrics and surgery. He has been on the gynecological teaching faculty of the U. of L. since 1930.

He was president of the Jefferson County Medical Society in 1954, and vice president of the KSMA in 1960. He is a member of the Central Association of Obstetricians and Gynecologists and a Fellow of the American College of Surgeons.

During World War II, Doctor Cox served 44 months in the Medical Corps. He was chief of surgery of the 121st General Hospital in England and France and was discharged with the rank of Lt. Colonel.

Vice presidents elected at the same meeting were: Henry B. Asman, M.D., Louisville (Central); R. E. Pennington, M.D., London (Eastern); and Walter R. Johnson, M.D., Paducah (Western).

J. Vernon Pace, M.D., Paducah; and George P. Archer, M.D., Prestonsburg, who have served as alternate delegates to the AMA, were elected delegates to succeed W. Vinson Pierce, M.D., Covington; and George F. Brockman, M.D., Greenville, respectively. John C. Quertermous, M.D., Murray, was re-elected as an alternate delegate. Named to fill the other two alternate delegate posts were: J. Thomas Giannini, M.D., Louisville; and Carl C. Cooper, M.D., Bedford.

J. Farra Van Meter, M.D., Lexington, is traveling in Japan where he will give several medical talks. Doctor Van Meter is a former chairman of the KSMA Board of Trustees and is presently chairman of the Council on Allied Medical Services.

AMA Clinical Meeting To Make Study of Hereditary Ills

A study of heredity as it relates to human ills will be presented as a feature of the 15th annual clinical meeting of the American Medical Association, November 26-30 at Denver.

"Genes, Chromosomes and Human Disease" will be the general subject of the section, under the chairmanship of Leroy J. Sides, M.D., Denver. Topics will include "The Gene and the Protein Molecule," "Genes and Chromosomes," "Hereditary Aspects of Disease," and "Hemoglobinopathies."

A special section on space medicine, an interesting series of papers to be presented at special breakfast programs, color television programs, and outstanding medical motion pictures will be other features of the meeting.

Board of Trustees Selects Drs. Norvell, Hambley

Wyatt Norvell, M.D., New Castle, was elected chairman of the KSMA Board of Trustees at its reorganizational meeting on September 21. Doctor Norvell succeeds J. M. Stevenson, M.D., Brooksville, whose term as Ninth District Trustee expired in September. William C. Hambley, M.D., Pikeville, Trustee from the Fourteenth District, was elected vice chairman of the Board.



Wyatt Norvell, M.D.

Also elected to the Executive Committee was Ralph D. Lynn, M.D., Elkton, Third District Trustee.

Three new Trustees were elected by the House. They were: Howell J. Davis, M.D., Owensboro, to succeed Walter L. O'Nan, M.D., Henderson, as Trustee from the Second District; Mitchell B. Denham, M.D., Maysville, to succeed Doctor Stevenson as Trustee from the Ninth District; and Clyde C. Sparks, M.D., Ashland, to succeed Charles B. Johnson, M.D., Russell, as Trustee from the Thirteenth District.

Douglas E. Scott, M.D., Lexington, was re-elected to the Board of Trustees from the Tenth District; and Doctor Norvell was re-elected as Seventh District Trustee.

Postgraduate Course To Be Held On Nuclear Disaster

Eight guest speakers will be featured on the program on "The Physician's Responsibility in Nuclear Disaster," to be held by the KSMA Postgraduate Medical Education Office at the University of Kentucky Medical Center on December 7.

The program of speakers and their topics, beginning at 9:00 a.m., is:

Panel on "Consequences of Thermonuclear Explosion in the Lexington Area"

Moderated by Joseph Shaeffer, colonel (retired) in the Medical Corps; director of medical education, Santa Rosa Hospital, San Antonio, Texas; previously chief of the department of Atomic Casualty Studies; Walter Reed Army Hospital Institute of Research.

"Thermal Blasts and Effects"

Col. Shaeffer

"Acute Radiation Effects"

Carl L. Hansen, Jr., M.D., chief of the bionucleonic section, director of professional services of the office of the Surgeon General, Washington, D. C.

"Hazards of the Acute Fallout Situation"

Robert A. Conrad, M.D., chief of the Marshall Islands Medical Survey, department of medicine, Brookhaven National Laboratories, Brookhaven, N. Y.

"Principles of Individual Protection"

Solomon Garb, M.D., University of Missouri School of Medicine

Film "Effects of Thermonuclear Explosion in Japan and the Marshall Islands"

"The Role of the County Medical Society in the Organization of Civil Defense Program"

Robert Leslie Smith, M.D., deputy chief, director of health mobilization, Public Health Service, department of Health, Education, and Welfare, Washington, D. C.

"Medical Problems in Nuclear Weapon Warfare and Methods of Containment"

Joseph Goldstein, colonel, Medical Corps, U. S. Army; chief of nuclear energy division, consultant to the Surgeon General for Nuclear Medicine, U. S. Army Medical Research and Development Command, Washington, D. C.

"Physician's Role in Mass Casualty Care"

John W. Raker, M.D., assistant clinical professor of surgery, Harvard Medical School.

"Early Detection and Treatment of Radiation Injuries"

Frederick Stohlman, M.D., National Institute of Health, Bethesda, Md.

The program will be supported by the Medical Education for National Defense Fund.

According to a report in the *Advance-Yeoman*, Wickliffe, **Sydney G. Dyer, M.D.**, La Center, has entered active service. Doctor Dyer is a lt. colonel with the 439th Civil Affairs Company which was called to active duty.

Dr. Chumley Speaks To Medical Writers

Jack L. Chumley, M.D., Louisville, Associate Scientific Editor of *The Journal*, spoke during the 18th Annual Meeting of the American Medical Writers' Association. The meeting, held in New York City, October 6 and 7, was highlighted by a series of six two-day clinics.



Jack L. Chumley, M.D.

Born in Texas, Doctor Chumley received his medical degree from the University of Louisville in 1937 and now limits his practice to internal medicine. At the AMWA meeting he participated as an Editor Consultant in a clinic concerning "Respective Responsibilities of Journal Editors and of Authors for Literacy Competence."

The AMWA, a nonprofit corporation, is a national organization dedicated to improving form and methods of medical communication. Membership is open to physicians belonging to AMA or CMA and to laymen interested in medical writing and sponsored by two physicians.

AMA House Approves Dues Increase

The AMA's House of Delegates at the Annual Meeting in New York City in June approved an annual dues increase of $20. The increase will be put into effect in a two-year program.

An increase of $10 will take place on January 1, 1962, raising dues to $35 for that year; and another $10 increase will be effective January 1, 1963, bringing the total dues for that year and thereafter to $45. This is the first increase in annual AMA dues for active members since 1950 when they were established at $25.

In recommending a dues increase to the House of Delegates, the Board of Trustees said the programs of the American Medical Association are determined by the health needs of the nation and services required by physician members to keep them abreast of the latest developments in medicine.

Current AMA programs demand more money than its present income. A breakdown of income sources showed the following: Membership dues provided 22.8%; advertising, 50.1%; outside subscriptions, 14.4%; miscellaneous, 6.7%; exhibits, 3%; and investments, 3%.

Among the new and expanded programs for which the additional income from the dues increase will be used are: a new drug information program; a complete study of internships and residencies in the United States; a medical recruitment program; a program to combat mental illness; health and safety education programs for the public; and an international health program.

Tevis Bennett, Bill Harris Join KSMA Staff

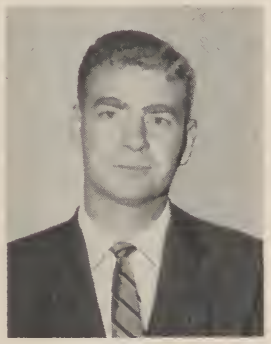
Tevis Bennett, a native of Muldraugh, has been appointed executive assistant on the KSMA Headquarters staff. Mr. Bennett, 28, is a 1961 graduate of the University of Kentucky School of Journalism. While at U. of K. he was daily news editor of the Kentucky Kernel and a member of Sigma Delta Chi, national professional journalism fraternity.



Tevis Bennett

Previous experience includes work as an announcer and advertising salesman for radio station WIEL, Elizabethtown. He also served with the U. S. Army from 1955-57, 18 months of which was spent as an information specialist in Portiers, France.

Mr. Bennett succeeds William E. Rudd, who joined the Association in December, 1959. Mr. Rudd has returned to his native Madisonville where he has taken over the post as office manager of Corum Construction Company.



William E. Rudd

The duties of the executive assistant include assisting the executive secretary with the administration of the Headquarters Office and working with various Association Councils and committees.

In another KSMA personnel change, William B. Harris, 32, has succeeded Friedrich Hertle, Ph.D., as executive director of the Postgraduate Medical Education office. Doctor Hertle, who began work with the Postgraduate office in January 1960, has returned to Germany.



William B. Harris

Mr. Harris, a native Louisvillian, received his B. S. degree from the University of Louisville in 1958, and was previously executive director of the Jefferson County Chapter of the National Foundation.

AAGP Restates Policy

As a result of the re-statement of policy by the Office of the American Academy of General Practice, Category I Credit for members of the Academy will not be given for any general session scientific program of a state medical association. This means that Category I Credit for the 1961 Annual Meeting will not be allowed.

KAGP members, however, will receive four hours credit for attending their own section meeting held Thursday morning, September 21 during the Annual KSMA session, according to James W. Davis, M.D., Louisville, chairman of the KAGP Commission on Education. The information relating to the general session did not arrive in time to be published in the September issue of The Journal of KSMA.

Fourth Annual Norton Seminar Scheduled For Dec. 14

The Fourth Annual Postgraduate Medical Seminar of the Norton Memorial Infirmary, Louisville, is scheduled for December 14. Co-sponsored by the Kentucky Chapter, American Academy of General Practice, the program has been accepted for six hours of Category I Credit.

Robert Lich, Jr., M.D., Louisville, is seminar chairman. He reports that there will be 15 scientific presentations by a total of 16 speakers. They are:

FBS—James Robert Hendon, M.D.

Physiological Derangement from Acute Arterial Obstruction in the Extremities"—Benjamin B. Jackson, M.D.

Cyclic Variations in Vaginal Cytology—Donald Lindsay Ware, M.D.

Physiological Principles in Neurological Diagnoses—R. Glen Spurling, M.D.

Physiologic Basis of Iron Deficiency Anemia—Ellis A. Fuller, M.D.

Laboratory Diagnosis of Steatorrhea—Stuart Graves, Jr., M.D.

Physiology and Pathology of Female Breast as Seen by X-Ray—Joan R. Hale, M.D.

Who Is the Father?—Malcolm L. Barnes, M.D.

The Diagnostic Physiology of Upper Abdominal Pain—George Benton Sanders, M.D.

The Interpretation of Renal Function Tests—Lonnie W. Howerton, M.D.

The Determination of Coronary Insufficiency—Walter S. Coe, M.D.

Physiology of the Postoperative Management of Gastro-Intestinal Surgery—Henry S. Collier, M.D., and R. Arnold Griswold, M.D.

The Physiologic Approach to Control of Gastric Functions in Peptic Ulcer Disease—Arthur M. Schoen, M.D.

The Physiologic Approach to Bursitis—Kenton D. Leatherman, M.D.

The Toxicity of Local Anesthetic Agents—James R. Flautt, Jr., M.D.

John H. Henderson, Jr., M.D., has opened an office in Lexington for general practice. Doctor Henderson received his medical degree from Ohio State Univesity in 1960 and interned at the Ohio State University Hospital.

Southern Medical Inaugurates Dr. McCarty President

A. Clayton McCarty, M.D., Louisville, has been inaugurated president of the Southern Medical Association to succeed Lee F. Turlington, M.D., Birmingham, Alabama. He was inducted during the Association's 55th Annual Meeting, November 6-9 in Dallas, Texas. The largest attendance ever was expected.



A. C. McCarty, M.D.

Doctor McCarty will preside at the Miami meeting of the Association in 1962. A full report of the Dallas meeting will be in the December issue of The Journal, including a list of Kentucky physicians who attended.

J. Duffy Hancock, M.D., Louisville, begins his last year as Councilor from Kentucky to the Southern Medical Association. A new Councilor-elect was scheduled to be appointed to succeed Doctor Hancock when his term expires in November 1962, Doctor McCarty said.

Several symposia highlighted the meeting. Topics included, "When Disaster Strikes!" "Cosmetic Problems in General Practice," "Immunologic Disorders and Transplantations," and "Medicoeconomics."

Second Athletic Injury Conference Held

The West Kentucky Athletic Injury Prevention Conference was held in Bowling Green on October 14 under the joint sponsorship of the Kentucky State Medical Association and the Kentucky High School Athletic Association. A similar conference was held in Lexington on August 12.

William H. Crowdus, Franklin, president of the KHSAA, presided in the absence of Carroll L. Witten, M.D., Louisville, who was unable to attend. Mr. Crowdus said he was highly pleased with the attendance of 85 and the content and depth of the program.

Participating in the program were: Owen B. Murphy, Jr., M.D., Lexington, speaking on "The Matter of Athletic Injuries"; George M. Gumbert, M.D., Lexington, talking about "The Matter of Injury Prevention"; and John L. Wolford, M.D., Louisville, who spoke on "The Importance of Physical Fitness."

Mrs. Roles Speaks On AMPAC At Auxiliary Conference

Three Kentuckians attended the Annual Conference of Presidents and Presidents-elect of the Woman's Auxiliaries to State Medical Associations held in Chicago in October. Mrs. Guy Morford, Owensboro, president, and Mrs. James Rich, Lexington, president-elect, attended representing the Kentucky Auxiliary. All state auxiliaries were represented with an average of two attending from each state.

Mrs. Earl W. Roles, Prospect, immediate past-president of the KSMA Auxiliary, attended as a guest speaker. Mrs. Roles spoke on the new American Medical Political Action Committee, of which she is a member. She urged physicians and auxiliary members to "study the information and materials dispersed by AMPAC, compare it with other source materials and think for yourselves concerning the various measures, issues and problems, and then, with knowledge, conviction and authority, speak your thoughts and ideas to others." Speaking at a luncheon meeting, Mrs. Roles shared the spotlight with George M. Fister, M.D., president-elect of the AMA.

She was also scheduled to attend the second meeting of AMPAC on October 21 and 22. The first meeting, held in August, was involved primarily in setting up the mechanics of the group and drafting a constitution.

Garfield Howard, M.D., Crab Orchard, announced his retirement as a practicing physician on September 7. Doctor Howard is a 1907 graduate of the Louisville Hospital College of Medicine.



Taking part in the Athletic Injury Prevention Conference in Bowling Green were from left to right: Jimmy Fiex, Western Kentucky State College football coach who made the arrangements for the meeting; William H. Crowdus, Franklin, president of the Kentucky High School Athletic Association, who presided; and program speakers, John L. Wolford, M.D., Louisville; George M. Gumbert, M.D., Lexington; and Owen B. Murphy, Jr., M.D., Lexington.

Dr. Pierce Retires As Delegate To AMA

W. Vinson Pierce, M.D., Covington, who has served as KSMA's Delegate to the AMA for seven years and has been senior delegate for the past four years, is retiring as of December 31, 1961.



W. Vinson Pierce, M.D.

During the time that Doctor Pierce was in the AMA House of Delegates, he was given numerous important speaking assignments by the AMA. Two years ago he was appointed on the AMA's new insurance committee and last winter he was named one of three AMA representatives on the Joint Commission for the Promotion of Voluntary Non-Profit Prepayment Health Plans.

Following Doctor Pierce's explanation of withdrawing, Robert C. Long, M.D., Louisville, KSMA's second Delegate to the AMA spoke briefly on the high regard in which delegates from other states held Doctor Pierce, the excellent leadership he had given the KSMA delegation, and the influence that he had developed in the AMA House. After these remarks, the House gave Doctor Pierce a standing ovation in which there was lengthy applause.

Doctor Pierce serves as the chairman of KSMA's Advisory Commission to Blue Shield. He is also a member of the Board of Directors of Kentucky Physicians Mutual and a past-president of the Board.

Film Released On AMA Annual Meeting

The Schering Corporation in cooperation with the AMA Department of Medical Motion Pictures and Television has made available Medifilm Report III, presenting highlights of the AMA's 110th Annual Meeting in New York City.

Featured are scientific exhibits, lectures and panel discussions. Of special interest is a demonstration of external cardiac massage at the 1961 Gold Medal Award exhibit. A mannikin is used to show the actual technique of closed chest cardiac massage. The film concludes with E. Vincent Askey, M.D., outgoing AMA president speaking on the theme of the 1961 convention—teamwork in medicine.

The 16 mm. black and white sound film runs 33 minutes long. Interested medical and allied groups may obtain a copy by writing to the American Medical Association, 535 North Dearborn Street, Chicago 10, Ill., or to the Audio-Visual Department, Schering Corporation, Union, N. J.

Psychiatrists Choose Dr. Parker

The Kentucky Psychiatric Association has chosen Joseph Parker, Jr., M.D., Lexington, as the group's president-elect. Doctor Parker is chairman of the Department of Psychiatry at the University of Kentucky Medical Center.

15 Kentuckians Inducted By College of Surgeons

Fifteen Kentucky surgeons have been inducted as new Fellows of the American College of Surgeons. The cap-and-gown ceremony took place October 6, during the five-day Clinical Congress of the College held in Chicago. Approximately 1,103 were made Fellows.

Kentucky surgeons receiving Fellowships were: Ernest C. Lineberger, M.D., Ft. Campbell; Anselm C. Hohn, M.D., Harlan; Graydon A. Long, M.D., and Owen B. Murphy, M.D., both of Lexington; Merle M. Mahr, M.D., Madisonville; Theodore T. Myre, M.D., Paducah; Herman W. Blankenberg, M.D., and Warren H. Proudfoot, M.D., both of Pikeville.

Also the following Louisville doctors were inducted: Robert R. Burnam, III, M.D.; Benjamin B. Jackson, M.D.; William W. Johnson, M.D.; G. David McClure, M.D.; Heinz Oppenheim, M.D.; George I. Uhde, M.D.; and Edward Warrick, Jr., M.D.

The A. C. S., founded in 1913 to establish standards of competency and character for specialists in surgery, has grown in 48 years' time from a founding group of 450 to a total membership of approximately 24,500 in 71 countries.

Dr. Coxwell Elected By Dental Group

A. B. Coxwell, D.M.D., Louisville, executive secretary of the Kentucky Dental Association, has been elected president of the State Societies Officers' Conference, affiliated with the American Dental Association He had previously served as secretary.



A. B. Coxwell, D.M.D.

Doctor Coxwell's election came during the 102nd annual ADA meeting held in Philadelphia, October 16-19. He will serve a two-year term.

The American College of Dentists, meeting in conjunction with the ADA annual meeting, elected Philip E. Blackerby, Jr., D.D.S., as president. Doctor Blackerby is a former dean of the University of Louisville Dental School and is now associate general director and chief of the division of dentistry of W. K. Kellogg Foundation, Battle Creek, Mich.

EENT Society Elects Officers

New officers of the Kentucky Eye, Ear, Nose and Throat Society were elected at a meeting on Thursday, September 21. They were:

President—George I. Uhde, M.D., Louisville

President-elect—William J. Oldham, M.D., Owensboro

Secretary-Treasurer—Alvin C. Poweleit, M.D., Covington.

Reports, Resolutions, Discussions Highlight House of Delegates Sessions

Thirty-four annual reports and ten resolutions were considered by the 1961 meeting of the House of Delegates at its two sessions, Monday evening, September 18, and Wednesday evening, September 20, according to Speaker Sam A. Overstreet, M.D., Louisville.

The December issue of The Journal of KSMA will carry the full report of all the officers, Board of Trustees, Councils and Committees to the 1961 meeting of the House and the action of the House on each report. The full report does not appear in this issue because of the lack of time to prepare, edit and process.

The House voted to adopt a resolution presented by the Jefferson County Medical Society to support the position of the American Medical Association on the matter of relationships between physicians and osteopaths. The KSMA Board of Trustees had previously endorsed the resolution.

The subject of Medical Discipline was considered as the result of a resolution submitted by the Muhlenberg County Medical Society and the Laurel County Medical Society. The latter called for the appointment of a committee to make a thorough study of the problem and the former requested the approval of recommendations of the AMA for the improvement of medical discipline. Both resolutions passed.

In a warmly debated action, the House turned down the recommendation of Reference Committee No. 5 on the so-called "pay all" or "Indiana Plan." The KSMA advisory commission to Blue Shield had recommended that the Association permit local county medical societies to enter into an arrangement with Blue Shield whereby the present schedule of allowances would be accepted in full payment of fees unless there was previous consultation with the patient. The Reference Committee report asking for the rejection of the Blue Shield Advisory Commissions report was defeated by a two-to-one margin.

The House approved the Campbell-Kenton resolution concerning the internship program. This resolution asked the KSMA "to recommend to the AMA that those hospitals having a significant residency program either eliminate their internship program or reduce it to a minimum compatible with good patient care."



Members of Reference Committee No. 3 discuss the report of the Council on Legislative Activities submitted to it by the House of Delegates. Seated left to right, they are: Robert D. Shepard, M.D., Lexington; Frederick R. Scroggin, M.D., Dry Ridge, and Mrs. Florene Johnson, KSMA Headquarters Office staff. Standing are Paul J. Sides, M.D., Lancaster, left, and R. E. Pennington, M.D., London.



James M. Stevenson, M.D., Brooksville, left, chairman of the Board of Trustees, administers the oath of office to the new president, Gaithel L. Simpson, M.D., Greenville.

The report of Reference Committee No. 3 dealing with legislative activities was read and approved without amendment. High praise was given the Council on Legislative Activities for its efforts during the past year to contain the King Bill.

Reference Committee No. 3 called attention to the valuable services rendered by the KSMA key-man system, complimented it on its excellent work and urged full support of it by the membership.

Two resolutions, one by the Campbell-Kenton Medical Society and the other by the Daviess County Medical Society calling for the cooperation with and continuing evaluation of the indigent care program in an effort to make it more effective, were passed by the House.

The House also decided, after considering the matter on previous occasions, to give its blessings to the formation of a Kentucky Chapter of the American Association of Medical Assistants. This has been recommended to the House on different occasions by the Council on Communications and Public Service.

The Campbell-Kenton County resolution on the ECFMG program relating to the intern matching program was recommended by Reference Committee No. 2. The only minority report submitted during the second meeting of the House disagreed with this proposal. Following discussion, the House accepted an amending statement which is as follows: "It is the intent of the House of Delegates that KSMA oppose the forcing of foreign medical graduates into the matching internship program of the Education Council for Foreign Medical Graduates."

Two of the ten resolutions, one from the Daviess



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Research in the Service of Medicine



David M. Cox, M.D., Louisville, makes his acceptance speech to the House of Delegates after having been chosen president-elect of the KSMA at the second session of the House on September 20.

County Medical Society and the other from the Fayette County Medical Society, relating to the Indiana Plan were withdrawn.

Reference Committee No. 1 considered a total of twelve reports, most of which were reports of officers and trustees. In its commendation of the Board, Reference Committee No. 1 called attention to "the tremendous amount of work done by the Board of Trustees in behalf of the KSMA and expressed our sincere appreciation for its efforts." Reference Committee No. 1 also complimented the improvements in The Journal of KSMA. Special note was taken of the valuable services by retiring President Elliott.

Reference Committee No. 7 highly complimented the report of the Woman's Auxiliary to the KSMA and "the Committee recommends that the Society commend the Woman's Auxiliary for the excellent work during the year." The report was made by Mrs. Earl W. Roles, Prospect, retiring President of the Auxiliary.

Nominating Committee Announced

Election of the five-member Nominating Committee for the 1962 Annual Meeting has been announced by Speaker of the House Sam A. Overstreet, M.D., Louisville.

Chosen at the final session of the House of Delegates on September 20, they are: W. H. Bryant, M.D., Glasgow; A. D. Butterworth, M.D., Murray; M. O. Darnell, M.D., Lexington; Russell L. Hall, M.D., Prestonsburg; and William E. Oldham, M.D., Louisville. A chairman will be elected at the Interim Meeting of the KSMA on February 22, 1962, at Owensboro.

Was Your Delegate Present?

ROLL CALL—1961 House of Delegates* KSMA Annual Meeting

		First Session	Second Session
	OFFICERS		
Speaker	Sam A. Overstreet	Present	Present
Vice Speaker	Garnett J. Sweeney	Present	Present
President	Richard G. Elliott	Present	Present
President-Elect	Gaithel L. Simpson	Present	Present
Vice-President	Foster D. Coleman	Present	Present
Vice-President	Wendell V. Lyon	.....	.....
Vice-President	James T. Gilbert	Present	.....
Secretary	Woodford B. Troutman	Present	Present
Treasurer	Delmas M. Clardy	Present	Present
Delegate to the AMA	W. Vinson Pierce	Present	Present
Delegate to the AMA	Robert C. Long	Present	Present
Delegate to the AMA	George F. Brockman	Present	Present
Alternate Delegate to the AMA	J. Vernon Pace	Present	Present
Alternate Delegate to the AMA	George P. Archer	Present	.....
Alternate Delegate to the AMA	John C. Quertermous	Present	Present
	TRUSTEES		
District			
First	Hugh L. Houston	Present	Present
Second	Walter L. O'Nan	Present	Present
Third	Ralph D. Lynn	Present	.....
Fourth	Dixie E. Snider	Present	.....
Fifth	Carlisle Morse	Present	Present
Sixth	John P. Glenn	Present	Present
Seventh	Wyatt Norvell	Present	Present
Eighth	Dexter Meyer	Present	Present
Ninth	J. M. Stevenson	Present	Present
Tenth	Douglas E. Scott	Present	Present
Eleventh	Hubert C. Jones	Present	.....
Twelfth	Thomas O. Meredith	Present	Present
Thirteenth	Charles B. Johnson	Present	Present
Fourteenth	William C. Hambley	.....	Present
Fifteenth	Keith P. Smith	Present	Present
	PAST PRESIDENTS		
1959	Irvin Abell, Jr.	Present	Present
1958	R. W. Robertson	Present	Present
1957	Edward B. Mersch	.....	.....
1956	Richard R. Slucher	Present	Present
1955	J. Gant Gaither	.....	.....
	DELEGATES		
	First District		
County		**First Session**	**Second Session**
BALLARD	Jesse M. Hunt	Present	Present
CALLOWAY	John C. Quertermous	Present	Present
CARLISLE	John T. O'Neill	.....	.....
FULTON	R. Ward Bushart	.....	.....
GRAVES	W. H. Fuller	Present	Present
HICKMAN	V. A. Johnson	.....	.....
LIVINGSTON			
McCRACKEN	Walter Johnson	Present	Present
	Walker Turner	Present	Present
	Eugene Sloan	Present	Present
MARSHALL	William S. Colburn	.....	Present
	Second District		
DAVIESS	Guy Morford (Alter.)	Present	Present
	John S. Oldham	Present	Present
	William Woolfolk	Present	Present
HANCOCK			
HENDERSON	Kenneth Eblen	Present	Present
McLEAN	Everett Coleman	.....	.....
OHIO	Oscar Allen	Present	Present
UNION			
WEBSTER	William W. Wainer	Present	Present
	Third District		
CALDWELL			
CHRISTIAN	Gabe A. Payne	.....	.....
	Harvey B. Stone	Present	Present
CRITTENDEN	R. M. Brandon	.....	.....
HOPKINS	Loman C. Trover	Present	.....
	F. A. Scott	Present	.....
LYON	M. H. Moseley	.....	.....
MUHLENBERG	C. J. Shipp	Present	Present
TODD	J. C. Woodall	Present	Present
TRIGG	Thornton Bryan (Alter.)	Present	.....
	Fourth District		
BRECKINRIDGE	James C. Sills	Present	.....
BULLITT	Bruce Hamilton	Present	Present
GRAYSON			
GREEN	Robert Shuffett	.....	.....
HARDIN	Charles F. Long	Present	Present

HART	Fred J. Cecil	Present	.....
LARUE	J. D. Handley	.....	.....
MARION	B. J. Baute	.....	Present
MEADE	George E. Clark	.....	.....
NELSON	Henry S. Spalding (Alter.)	.....	Present
SPENCER	William K. Skaggs	.....	.....
TAYLOR	H. F. Chambers	Present	Present
WASHINGTON	M. A. Coyle	Present	Present
	Fifth District		
JEFFERSON	William C. Buschemeyer	Present	Present
	Kenneth P. Crawford	Present	Present
	Nathan I. Handelman	Present	Present
	George Kimbrough	Present	Present
	Daniel E. Mahaffey	Present	.....
	Henry Post	Present	Present
	Carroll Robie	Present	Present
	Stanley E. Smith	Present	Present
	Robert S. Tillett	Present	Present
	Charles Bisig	Present	Present
	Austin Bloch	Present	Present
	Harold Eskind	Present	Present
	David Kinnaird	Present	Present
	Paul Mapother	Present	Present
	Harry Pfingst	Present	Present
	George Sehlinger	Present	Present
	David Thurman	Present	Present
	Robert Woodard, Jr.	Present	.....
	C. Melvin Bernhard	Present	Present
	Ralph M. Denham	Present	Present
	James B. Douglas	Present	Present
	Robert L. McClendon	Present	Present
	William E. Oldham	Present	Present
	B. Frank Radmacher, Jr.	Present	Present
	R. O. Joplin (Alter.)	Present	Present
	George I. Uhde	Present	Present
	J. B. Bell (Alter.)	Present	Present
	William P. VonderHaar	Present	.....
	Sixth District		
ADAIR	James C. Salato	Present	Present
ALLEN	V. E. Scherer	Present	.....
BARREN	W. H. Bryant	Present	.....
	Eugene L. Marion (Alter.)	.....	Present
BUTLER	D. G. Miller, Jr.	.....	.....
	John C. Burris (Alter.)	.....	Present
CUMBERLAND	N. K. Kirby	Present	Present
EDMONSON	M. B. Wilkes	.....	.....
LOGAN	C. V. Dodson	Present	Present
METCALFE	P. D. Hitchcock	.....	.....
MONROE	C. A. Crabtree	.....	.....
SIMPSON	L. F. Beasley	.....	Present
WARREN	Harold Keen	Present	.....
	J. O. Willoughby (Alter.)	Present	Present
	Seventh District		
ANDERSON	Boyd Caudill	Present	.....
CARROLL	J. O. Mattax	.....	.....
FRANKLIN	James Ramsey	Present	.....
GALLATIN	G. F. Harris	.....	.....
GRANT	F. R. Scroggin	Present	Present
HENRY	S. B. May	.....	.....
OLDHAM	Ed Houchin	Present	.....
OWEN	Maurice Bowling	.....	.....
SHELBY	Robert W. Hamm (Alter.)	Present	Present
TRIMBLE	Carl Cooper	Present	Present
	Eighth District		
BOONE	Joseph F. Daugherty	Present	Present
CAMPBELL-	Robert Hoffman	Present	Present
KENTON	Donald Stevens	.....	Present
	Donald Janney	Present	Present



Future, present, and past presidents of the KSMA met at the Annual Meeting. Left to right, they are David M. Cox, M.D., Louisville, president-elect; Gaithel L. Simpson, M.D., Greenville, president; and Richard G. Elliott, M.D., Lexington, immediate past-president.

	Thomas McElhinney	.....	Present
	Richard Allnutt	.....	Present
	Paul Klingenberg	Present	Present
	James J. Kelly	.....	Present
	Ninth District		
BATH			
BOURBON	Richard J. Wever	.....	.....
BRACKEN	Carl A. Marquardt	.....	.....
FLEMING	R. W. Fidler	.....	.....
HARRISON	H. H. Moody	Present	.....
MASON	M. B. Denham	Present	Present
NICHOLAS			
PENDLETON	Robert L. McKenney	.....	.....
ROBERTSON			
SCOTT	R. G. Wheeler	Present	Present
	Tenth District		
FAYETTE	M. C. Darnell	Present	Present
	N. L. Bosworth	Present	Present
	Robert B. Warfield	Present	Present
	Robert D. Shepard	Present	Present
	Carl H. Fortune	Present	Present
	Maurice Kaufmann	Present	Present
	E. C. Strode	Present	.....
	T. R. Bryant (Alter.)	.....	Present
	J. H. Saunders	Present	.....
	Harvey Chenault	Present	Present
	Glenn U. Dorroh	Present	.....
JESSAMINE	J. S. Williams	Present	Present
WOODFORD	Ben Roach	Present	Present
	Eleventh District		
CLARK	T. E. Averitt (Alter.)	.....	.....
ESTILL	R. R. Snowden	.....	.....
JACKSON			
LEE	J. M. Smith	.....	.....
MADISON	Douglas Jenkins	Present	Present
	E. C. Whitaker	Present	Present
MENIFEE	D. L. Graves	.....	.....
MONTGOMERY	J. M. Bush	Present	Present
OWSLEY	M. B. Gabbard	.....	Present
POWELL	S. T. Scrivner	.....	.....
WOLFE	Paul F. Maddox	.....	.....
	Twelfth District		
BOYLE	Chris Jackson	.....	.....
CASEY			
CLINTON	Floyd B. Hay	.....	.....
GARRARD	Paul Sides	Present	Present
LINCOLN	H. I. Frisbie	Present	Present
McCREARY	M. A. Winchester	.....	.....
MERCER	George F. Ballard	.....	.....
PULASKI	B. L. Ramsey	.....	Present
ROCKCASTLE	George H. Griffith	.....	.....
RUSSELL	Charles E. Peck	.....	.....
WAYNE	Frank L. Duncan	.....	.....
	Thirteenth District		
BOYD	Clyde C. Sparks	Present	Present
	Guy C. Cunningham	Present	Present
CARTER	J. Watts Stovall	Present	Present
ELLIOTT	John F. Greene	.....	.....
GREENUP			
LAWRENCE	G. P. Carter	.....	Present
LEWIS			
MORGAN	Morris L. Peyton	Present	Present
ROWAN			
	Fourteenth District		
BREATHITT	Price Sewell, Jr.	.....	.....
FLOYD	Russell L. Hall	Present	Present
JOHNSON	James W. Archer	Present	Present
KNOTT	Gene T. Watts	.....	.....
LETCHER	T. M. Perry	Present	Present
MAGOFFIN			
MARTIN			
PERRY	A. B. Pigman	.....	.....
PIKE			
	Fifteenth District		
BELL	C. B. Stacy	Present	.....
CLAY	W. E. Becknell	Present	Present
HARLAN	John H. Willard (Alter.)	Present	Present
	E. M. Howard	Present	Present
KNOX	F. X. Sommer	Present	Present
LAUREL	R. E. Pennington	Present	Present
LESLIE			
WHITLEY	W. M. Buttermore	Present	Present
TOTAL		135	125

** The information in the roll call was taken from the attendance record cards signed by the delegates prior to the meetings on September 18 and 20.*

NEW **SPECIAL COUGH FORMULA**
for Children

Pediacof

Trademark

SOOTHING DECONGESTANT AND EXPECTORANT

Each teaspoon (5 cc.) contains:

Codeine phosphate	5.0 mg.
Neo-Synephrine® hydrochloride (brand of phenylephrine hydrochloride)	2.5 mg.
Chlorpheniramine maleate	0.75 mg.
Potassium iodide	75.0 mg.



Bright red, pleasant tasting, raspberry flavored syrup

Dosage:

Children from 6 months to 1 year, 1/4 teaspoon; 1 to 3 years, 1/2 to 1 teaspoon; 3 to 6 years, 1 to 2 teaspoons; 6 to 12 years, 2 teaspoons. Every four to six hours as needed.

How Supplied:
Bottles of 16 fl. oz.

Exempt Narcotic

Winthrop
LABORATORIES
New York 18, N. Y



NEOCHOLAN®

Your patient will often respond promptly to Neocholan therapy. It greatly increases the flow of thin, nonviscid bile and corrects biliary stasis by flushing the biliary system. It also relaxes intestinal spasm, resulting in an unimpeded flow of bile and pancreatic juice into the small intestine. Neocholan helps to promote proper digestion and absorption of nutrients. It also encourages normal peristalsis by restoring intestinal tone.

Each tablet provides: Dehydrocholic Acid Compound, P-M Co. 265 mg. (Dehydrocholic Acid, 250 mg.); Homatropine methylbromide 1.2 mg.; Phenobarbital 8.0 mg. Supplied in bottles of 100 tablets.

PITMAN-MOORE COMPANY
DIVISION OF THE DOW CHEMICAL COMPANY
INDIANAPOLIS 6, INDIANA



Guests at the President's Luncheon on September 20 heard T. C. Petersen, Chicago, Ill., spell out the physician's role in politics in a talk entitled, "This Too Is The Practice Of Medicine."

President's Luncheon Speaker Stresses Free Enterprise

The AMA and the American Farm Bureau Federation have much in common in that both are minority groups, but their influence far exceeds the number they represent. This was the opening statement of Mr. T. C. Petersen of the AFBF in his talk, "This Too Is The Practice of Medicine," at the President's Luncheon on Wednesday, September 20, during the Annual Meeting of the KSMA.

He continued by saying that both the AMA and the AFBF are among the few supporters of the American Free Enterprise System, and that if they did not exert influence, they would be socialized.

He asked—and answered—three questions. They were:

1. What is the setting we find ourselves in?

To this he said that Russia is bound and determined to take us over. Her objective is world dominance and she will do anything to obtain this. Russia *does* want peace, he said, but peace predicated on her victory over us. There are two things that Russia respects and they are military strength and economic strength.

2. What is our one great hope?

The one arsenal of defense we have as a nation is our productive capacity. How well we protect ourselves is up to how well we maintain our productive capacity and our way of life. How well we do this is up to how good our government is. Our government is no better than the people we elect to office.

3. What is our responsibility?

We must have the kind of people in office who agree with our point of view and measure up to our criteria. You (doctors) have influence; assert it. Use it with patients, community leaders, friends. Offer your help so you can be effective and instrumental in nominating and electing people to office who will support American Free Enterprise.

President's Luncheon Is Scene Of Awards Presentation

Recipients of KSMA's two top awards were honored at the President's Luncheon on September 20. They were A. Clayton McCarty, M.D., and Mrs. Eva Ray Wunderlich, both of Louisville.

Doctor McCarty received the Distinguished Service Medal. The R. Haynes Barr Award, given each year to a lay person for outstanding contributions in the field of public health and medical care, went to Mrs. Wunderlich.

President of the American Geriatrics Society and president-elect of the Southern Medical Association,



William H. Bizot, M.D., Louisville, chairman of the KSMA Awards Committee, holds the plaque awarded to Mrs. Eva Ray Wunderlich, left, winner of the R. Haynes Barr Award. Looking on is A. Clayton McCarty, M.D., Louisville, who was presented the Distinguished Service Medal.

Doctor McCarty is also a former vice president of the Kentucky State Medical Association.

For many years, Doctor McCarty has headed the Kentucky Advisory Committee to Selective Service on military service for physicians. A veteran of four branches of the armed services, during World War II he was an Army colonel commanding the 100th General Hospital in France.

Doctor McCarty, who retired from a busy practice of internal medicine in Louisville after an illness in 1959, received his M.D. degree from the University of Pennsylvania in 1923. He has served on various KSMA committees, headed the KSMA's first committee on aging, is a former president of the Jefferson County Medical Society, and a founder of the Kentucky Chapter, Arthritis and Rheumatism Foundation.

One of the organizers of the World Medical Association, Doctor McCarty, a native of Henderson, is a



drugs anonymous

One of the several hastily conceived and potentially dangerous suggestions for reducing drug costs is generic-name prescribing. The proponents of generic-name prescribing claim that it will lower drug costs significantly and—through supervision by the Federal Government—provide quality equivalent to that of trademarked drugs. We maintain that these claims are false. Here are some authoritative answers to the principal questions posed by generic-name prescribing.

How much money would be saved if all prescriptions were written for generic-name drugs?

"The [Rhode Island] Division of Public Assistance examined 10,000 drug prescriptions for welfare recipients for the purpose of determining the actual savings . . . of generic versus trade-name drugs. The drugs had cost $28,000. Substituting generic drugs whenever possible would have provided a saving of less than 5 per cent. Syracuse has made a similar study of drug costs with comparable results."

Rhode Island Medical Journal,
January, 1961

Are the savings worth the risk of sacrificing quality?

". . . it is unsafe [to prescribe generically] because there is not sufficient policing of our standards. . . ."

Lloyd C. Miller, Ph. D.
Director of Revision of the U.S.P.

"The naive belief that, if a product was not good, the FDA would prohibit its sale is just not realistic. . . . it is completely impossible for the FDA to check every batch of every product of every manufacturer. . . . Hence the integrity and reputation of the manufacturer assume unusual significance where drugs and health products are concerned."

Albert H. Holland, M.D.
formerly Medical Director of the
Food and Drug Administration

Smith Kline & French Laboratories, Philadelphia

SK&F

life fellow of the American College of Physicians.

At the time of her retirement last January, Mrs. Wunderlich had been associated with the Division of Licensure and Registration of the State Department of Health for 26 years. She had served under four Public Health Commissioners, and was director of the Licensure Division for the past 12 years.

A native of Warren County, Mrs. Wunderlich has distinguished herself as a guardian of public health. She has cooperated faithfully and effectively with the medical profession and law enforcement officials in their efforts to stamp out medical quackery and all forms of illegal medical practice.

When the Medical Practice Act was revised and strengthened, the group rewriting the Act sought the benefit of her experience and consulted her seeking her advice on the revision.

Dr. Royalty Wins KSMGA Golf Tournament

Edwin P. Solomon, M.D., Louisville, chairman of the KSMA Golf Committee has announced the winners of the 1961 Kentucky State Medical Golf Association tournament. Held at the Standard Country Club in conjunction with the KSMA Annual Meeting, the event attracted 45 physicians.

The winners were:

Championship cup (Low Gross)—D. M. Royalty, M.D., Lexington.

Low Net Cup—John C. Quertermous, M.D., Murray.

Senior Championship Cup—Thomas J. Overstreet, M.D., Lexington, winner for the fourth consecutive year.

Runner-up in the low net division was Earl Williams, M.D., Louisville (two physicians came up with identical scores in this division, but Doctor Williams was awarded the prize because he had the lowest handicap).

Each physician will keep possession of the traveling trophies until new championships are determined in the 1962 tournament.

KSMA New Members Are Honored By Luncheon

Twenty-nine new members of the KSMA, who have joined since September 1960, attended the New Member Luncheon on September 19. This was the third year the luncheon has been held to honor new members of the association. Held at the Brown Hotel, it was a feature of the opening day of the Annual Meeting.

N. L. Bosworth, M.D., Lexington, chairman of the KSMA Committee on Public Information and Service, moderated a panel discussion on services offered by the KSMA as a part of the program at the luncheon. Members of the panel and their topics were: Hoyt D. Garner, M.D., Louisville, "Services the KSMA Renders Its Members;" Carl Fortune, M.D., Lexington, "The Purpose of the KSMA;" and Donald Chatham, M.D., Shelbyville, "Services the KSMA Offers the Public."

Guests included four officers of the KSMA: Richard G. Elliott, M.D., Lexington, outgoing president; Woodford B. Troutman, M.D., Louisville, secretary; Delmas M. Clardy, M.D., Hopkinsville, treasurer; and J. M. Stevenson, M.D., Brooksville, chairman of the Board of Trustees

Other guests were: George W. Petznick, M.D., President of the Ohio State Medical Association; D. E. Greeneltch, M.D., President of the West Virginia State Medical Association; and two members of the KSMA Committee on Communications and Public Service—Auldin Bishop, M.D., Jeffersontown; and Carl C. Cooper, M.D., Bedford.

Full List of New KSMA Members Is Given

The following is the list of new members of the Association who joined the KSMA between September 1960 and September 1961. All were sent personal invitations to the New Member Luncheon held in their honor by the KSMA during the Annual Meeting.

Barren

Nikolas Russinovich, Glasgow

COMPARATIVE REGISTRATION FIGURES

KSMA Annual Meetings

	1952	1953	1954	1955	1956	1957	1958	1959	1960	1961
KSMA Members	693	786	924	938	923	1094	971	997	1021	996
Guest Physicians	67	75	150	122	157	178	166	165	203	194
Interns-Residents	73	100	148	106	105	142	108	128	105	102
Medical Students	252	292	284	299	305	328	269	280	289	237
Registered Nurses	16	31	25	55	15	28	22	34	25	31
Exhibitors	180	153	174	174	218	176	211	200	239	204
Guests	80	72	166	121	108	151	164	86	99	132
Technicians—										
Office Assistants	49	54	67	50	54	54	45	63	33	57
TOTAL ATTENDANCE	1410	1563	1938	1865	1885	2151	1956	1953	2014	1953



AHR

PHENAPHEN
(Basic formula)

In each capsule: Phenacetin (3 gr.) 194.0 mg.; acetylsalicylic acid (2½ gr.) 162.0 mg.; hyoscyamine sulfate 0.031 mg.; and phenobarbital (¼ gr.) 16.2 mg.

AHR AHR

PHENAPHEN No. 2

PHENAPHEN with Codeine ..... ¼ gr.

AHR AHR

PHENAPHEN No. 3

PHENAPHEN with Codeine ..... ½ gr.

AHR

PHENAPHEN No. 4

PHENAPHEN with Codeine ..... 1 gr.

SUPPLY: Bottles of 100 and 500 capsules.

sedative-enhanced analgesia

To each "according to his need" — maximum safe analgesia through time-and-pain-tested synergistic formulations, in four strengths for individualized prescription.

PHENAPHEN®

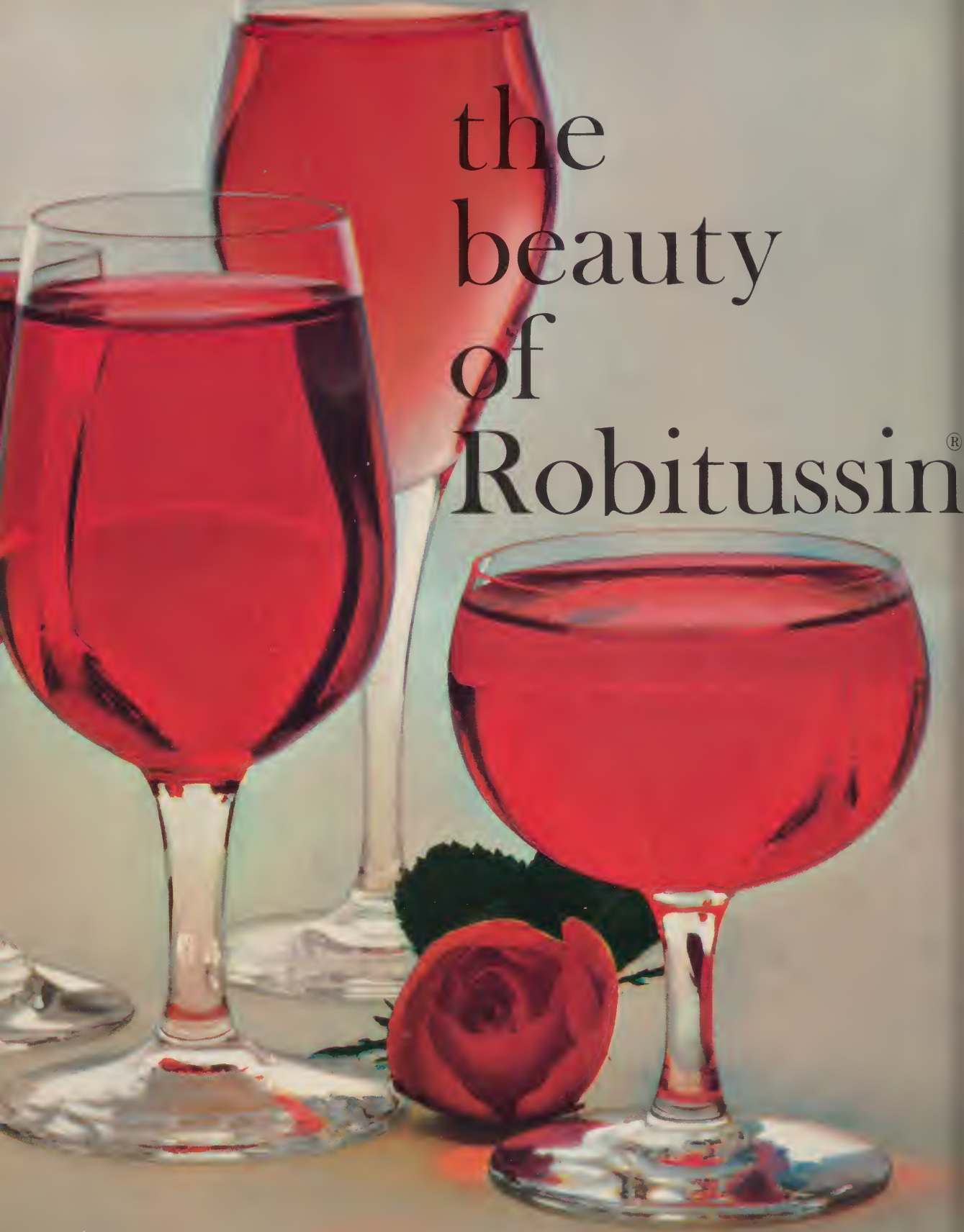
Robins

PHENAPHEN® WITH CODEINE

¼ gr., ½ gr., 1 gr.

A. H. ROBINS CO., INC., Richmond 20, Virginia

Making today's medicines with integrity . . . seeking tomorrow's with persistence



The real beauty of Robitussin is seen in the relief it brings to cough. By increasing the tracheal flow of respiratory tract fluid, Robitussin's glyceryl guaiacolate turns useless cough into productive cough. Efficient yet gentle, Robitussin helps the cough rid itself of the very irritants that cause it. And in more than a decade of use it has proved unquestionably safe, as well as consistently acceptable, to patients of all ages. Robitussin® is glyceryl guaiacolate, 100 mg. per 5 cc. dose; Robitussin® A-C adds prophenpyridamine maleate 7.5 mg., and codeine phosphate 10.0 mg. per 5 cc. dose (exempt narcotic).

A. H. Robins Company, Inc., Richmond 20, Virginia



New members of the KSMA at a luncheon held in their honor on September 19, heard Donald Chatham, M.D., Shelbyville, standing, center, discuss "Services the KSMA Offers the Public." Others participating in the program are at Doctor Chatham's right. They are, left to right, Hoyt D. Gardner, M.D., Louisville; Carl C. Fortune, M.D., Lexington; and N. L. Bosworth, M.D., Lexington, who moderated.

Bell

George L. Day, Horrogate, Tenn.

Bourbon

John C. Davenport, Paris

Boyd

William E. Bond, Ashland
Wallace M. King, Ashland
Eugene Slusher, Ashland

Breckinridge

William J. Gates, Cloverport

Calloway

Clegg F. Austin, Murray

Campbell-Kenton

William J. Beckmeyer, Ft. Thomas
Carl Brueggemann, Covington
Robert G. Draime, Newport
Roger A. Haas, Newport
Thomas L. Heavern, Jr., Newport
Clare C. Hugan, Jr., Covington
Douglas W. McKay, Covington
Richard J. Menke, Covington
William J. D. Mersh, Covington
James R. Wagstaff, Ft. Thomas

Clay

Stanley Hammons, Manhester

Cinton

Robert M Sigler, Albany

Daviess

William D. Bushong, Owensboro
R. Glenn Greene, Owensboro
William G. Ward, Owensboro

Fayette

Carl T. Clark, Lexington
John R. Cole, Lexington
K. W. Deuschle, Lexington
Richard D. Floyd, Lexington
James A. Halsted, Detroit, Mich.
John Roepke, Lexington
Hugh A. Storrow, Lexington
David B. Stevens, Lexington
W. B. Stewart, Lexington
Lucas N. Turk, Lexington
Wilk O. West, Lexington
James G. Wilhite, Lexington
William W. Winternitz, Lexington

Franklin

Richard B. Holt, Frankfort
Abbott B. Mitchell, Frankfort

Fulton

Thomas C. Lane, Fulton
R. T. Peterson, Jr., Fulton

Graves

Hilary L. Hunt, Mayfield
Jesse W. Page, Mayfield

Hardin

David S. Colvin, Radcliffe
Curtis L. Songster, Vine Grove

Harlan

Robert C. Burkhart, Washington, D. C.
Gilbert L. Hamilton, Harlan

Henderson

John L. Jenkins, Henderson
Sheldon Kessler, Henderson
Molloy G. Veal, Henderson

Hopkins

Orion W. Harris, Madisonville

Ferris I. Larsen, Earlington
John P. McNulty, Madisonville
Duane N. Tweeddale, Madisonville

Jackson

Leon W. Bowman, McKee

Jefferson

James E. Alvey, Louisville
Orville S. Clark, Louisville
Stuart P. Cohen, Louisville
Melton Comer, Louisville
Robert G. Cooper, Louisville
Thomas A. Courtney, Louisville
Richard A. Deutsche, Louisville
John E. Eckerle, Louisville
Edward J. Fadell, Louisville
N. K. Ford, Jr., Louisville
Nicholas W. Glaser, Louisville
Martin A. Goldman, Louisville
Philip Griever, Louisville
Lila Ann Hargan, Louisville
Herbert P. Hargett, Louisville
Lee A. Heine, Louisville
Kenneth W. Hodge, Louisville
Ronald W. Levine, Louisville
James A. Marshall, Jr., Louisville
Alfred E. Mattox, Louisville
Kenneth H. McCrocklin, Louisville
Charles J. McGoff, Louisville
Richard E. Mudd, Louisville
Marvin Murray, Louisville
Clinton R. Potts, Louisville
William H. Powers, Louisville
James Rieser, St. Matthews
Russell F. Scalf, Valley Station
David W. Scott, Louisville
Ralph M. Scott, Louisville
Mary A. Smith, Louisville
Harry D. Stambaugh, Louisville
Robert A. Stansbury, Louisville
Glenn R. Stoutt, Jr., Louisville
Donald M. Thomas, Louisville
Richard C. Turrell, Louisville
Charles I. Wabner, Louisville
Robert W. Wallace, Louisville
Ralph E. Whitehead, Louisville

Johnson

James E. Van Hoose, Paintsville

Laurel

Paul R. Smith, London

McCracken

Frank B. Crawford, Jr., Paducah
Theodore T. Myre, Paducah
Donal D. O'Sullivan, Paducah

Marion

S. M. George, Marion

Marshall

Robert A. Purvis, Gilbertsville

Monroe

James C. Carter, Tompkinsville

Nelson

Emmett W. Wood, Bardstown

Pike

Elvis R. Thompson, Stone
Marguerite E. Thompson, Stone

Pulaski

William O. Massey, Burnside
Glenn M. Shifley, Somerset

Rockcastle

Donald L. Arnett, Mt. Vernon

Russell

Hugh C. Smith, Russell Springs

Simpson

Fred D. Owens, Franklin

Trigg

Carl B. Rankin, Louisville

Union

Wallas N. Bell, Sturgis

Warren

Roy Cooksey, Bowling Green

Webster

Gerald H. McCord, Hopkinsville
Paul M. Taylor, Providence

Whitley

Frank H. Catron, Corbin
Harry A. Hamilton, Corbin

Auxiliary Elects Mrs. Rich

Mrs. James Rich, Lexington, was chosen president-elect and Mrs. Guy Morford, Owensboro, was installed as president of the Woman's Auxiliary to the Kentucky State Medical Association at its meeting held in conjunction with the KSMA Annual session.

Other new officers elected during the meeting are: Mrs. Keith Simth, Corbin, First Vice President; Mrs. John Y. Barbee, Bowling Green, Second Vice President; Mrs. William S. Swartz, Lexington, Third Vice President; Mrs. Ballard W. Cassady, Pikeville, Fourth Vice President; Mrs. Robert J. Salisbury, Mt. Sterling, Recording-Secretary; Mrs. Charles C. Kissinger, Henderson, Corresponding-Secretary; Mrs. William E. Hoy, Jr., Ashland, Treasurer; Mrs. Earl W. Roles, Prospect, Parliamentarian; Mrs. J. Andrew Bowen, Louisville, Editor, Blue Grass News; and Mrs. Marvin A. Lucas, Louisville, Co-editor, Blue Grass News.

Chest Physicians Pick Dr. Anderson

William H. Anderson, M.D., Harlan, was elected president and Robert H. Akers, M.D., Louisville, vice president of the Kentucky Chapter, American College of Chest Physicians during the chapter's meeting held at the annual session of the KSMA. Doctor Anderson succeeds Daniel N. Pickar, M.D., Louisville.

Dr. Thompson Elected

Kearns R. Thompson, Jr., M.D., Lexington, has been elected president of the Kentucky Orthopaedic Society to succeed Rudy J. Ellis, M.D., Louisville. Fred E. Coy, Jr., M.D., Louisville, was chosen secretary at the Society's session during the KSMA Annual Meeting.



Live and television audiences heard Edward R. Annis, M.D., Miami, Fla., discuss the "Facts and Fiction of Medical Care" on the evening of September 21. The appearance of Doctor Annis in Louisville in conjunction with the KSMA Annual Meeting, was sponsored by the Jefferson County Medical Society in cooperation with the KSMA. Others seated at the speaker's table were, left to right, Mrs. Earl W. Roles, Prospect, outgoing president of the Woman's Auxiliary to the KSMA; Daniel E. Costigan, M.D., president of the Jefferson County Medical Society; Doctor Annis; Robert C. Long, M.D., Louisville; Gaithel L. Simpson, M.D., Greenville, president of the KSMA; and Mrs. Hugh P. Adkins, Louisville, president of the Jefferson County Woman's Auxiliary.

Postgraduate Office Lists Courses Through Feb. 15

The KSMA Postgraduate Medical Education Office wishes to call attention to the forthcoming Postgraduate Course on "The Physician's Responsibility in Nuclear Disaster," which will be offered at the University of Kentucky Medical Center in Lexington, on December 7. This course will be under the direction of the Department of Radiology, and registration is scheduled to begin at approximately 8:30 AM.

In addition, during January there will again be a course on Electrocardiography Interpretation offered at Louisville General Hospital. The program is scheduled to be held on Wednesday evenings, from 7 until 9 PM, from January 10 through March 14. A syllabus will be used as a text for the course.

Detailed information on these programs may be obtained from the Postgraduate Medical Education Office, 104 West Chestnut Street, Louisville 2. The telephone number is JUniper 7-7135.

The complete listing follows:

November

Weekly through 1961	One-week training in the field of OB & GYN, each week during 1961; limitation to two physicians per week; fee of $50.00 includes room at Louisville General Hospital, if desired; 42 hours of Category I Credit granted by the AAGP; enrollment should be made at least two weeks before desired participation.
17	Conference on Chemotherapy in Cancer, University of Virginia, Charlottesville.
27-30	AMA Clinical Meeting—Denver.
29-30	Postgraduate course, "Clinical Pharmacology & Therapeutics," University of Buffalo, Buffalo, N. Y.

December

7	Postgraduate Course, "PHYSICIAN'S RESPONSIBILITY IN NUCLEAR DISASTER," University of Kentucky Medical Center, Lexington, Kentucky, under the Department of Radiology.
13-14	Postgraduate course, "Use and Interpretation of Diagnostic X-Ray," University of Buffalo, N. Y.
14	Fourth Annual Norton Memorial Infirmary Seminar, Louisville.

January 1962

10-March 14	Postgraduate Course, "ELECTROCARDIOGRAPHY INTERPRETATION," Wednesday evenings 7-9 PM, Louisville General Hospital, Louisville.
18	KAGP Northern Kentucky Seminar, Sheraton Gibson Hotel, Cincinnati, Ohio.
23-25	Postgraduate course, "Obstetric Problems in Private Practice," Medical College of Georgia, Augusta, Ga.

February

13-15	Postgraduate Course, "Cardiac Emergencies," Medical College of Georgia, Augusta, Ga., Fee $50.00.

According to an article in the Hickman *Courier*, **James E. Hamilton, M.D.**, has resigned as health officer for Fulton County and is practicing medicine in New Eddyville.

New Building Dedicated At Hazelwood TB Hospital

A construction and renovation program at Hazelwood Tuberculosis Hospital has produced a new three-story building and many added improvements. Dedication of the building, attended by several hundred people including Gaithel L. Simpson, M.D., Greenville, KSMA president, and many KSMA members, took place October 17 on the new sun deck.



C. C. Howard, M.D.

Louisville Mayor Bruce Hoblitzell, speaking at the dedication ceremony, said the State Tuberculosis Hospital Commission, under the chairmanship of C. C. Howard, M.D., Glasgow, was one of the outstanding governmental agencies.

Robert Matthews, State Finance Commissioner, represented Governor Bert Combs at the dedication. Mr. Matthews called the new building "most impressive," and commented that Kentucky is taking great strides in education, mental health, and tuberculosis treatment and control.

According to Thomas Layton, executive director of the State TB Hospital Commission, Hazelwood Hospital was started in 1907 and was taken over by the state in 1920. He said the new structure added approximately 100 beds, bringing the present total to 424. A patient library, occupational therapy workshop and classrooms are among other additions in the building.

Blue Shield Membership Reaches 48,154,563

The National Association of Blue Shield Plans has announced a total membership of 48,154,563 persons as of June 30, 1961. The new number is a result of a net gain of 201,558 new members during the second quarter of 1961.

A portion of the second quarter growth was attributed to the enrollment of North Idaho District Medical Service Bureau, Inc., the Blue Shield Plan headquartered in Lewiston, which services 32,579 members.

The national association also reported that Blue Shield now covers more than one-quarter of the total United States population and almost 15 per cent of the total Canadian population. Eleven Blue Shield Plans have enrolled more than 40 per cent of the people in the areas they serve.

U. of L. Gets New Assistant Dean

Charles Eugene Wagner, Ph. D., is the new Assistant Dean and Director of Admissions at the University of Louisville School of Medicine.



Charles E. Wagner, Ph. D.

Doctor Wagner, 38, has been assistant professor of anatomy at the medical school since 1955 and was instructor in anatomy from 1952-54. He took undergraduate work at Princeton University, where he holds an A. B. degree, and received his Ph. D. degree from Indiana University in 1954.

Last year he published an article entitled, "The Preservation of Glycogen in Fixed Tissues and Tissue



This view of the new wing of the Hazelwood Tuberculosis Hospital shows the sun deck on the roof. Inside are student nurse classrooms, a patient library, a rehabilitation suite, occupational therapy room, employee dining room, and other new features.

Sections" (J. Histochen & Cytochem. 8: 1: 74-75, 1960).

In his new position, Doctor Wagner will be in charge of student affairs.

U. of L. Announces Appointment Of Dr. Blankenship

The Board of Trustees of the University of Louisville has named Charles F. Blankenship, M.D., as acting chairman of the U. of L. Medical School's department of community health. He succeeds Russell Teague, M.D., State Health Commissioner, who resigned because of the shift of the State Health Department from Louisville to Frankfort.

Other Medical School faculty changes announced were:

Appointments: Donald Lindsey Ware, M.D., instructor in obstetrics and gynecology; Merritt O. Alcorn, M.D., and Anne Cameron, M.D., instructors in pathology; Imogene F. Gobble, M.D, instructor in psychiatry; Mrs. Anne R. Towner, lecturer in social sciences in the department of psychiatry; David H. Faegenburg, M.D., and Russell F. Scalf, M.D., instructors in radiology; Ahren Jacobsen, assistant professor of radiation physics in the department of radiology; and Richard C. McPherson, M.D., instructor in surgery.

Promoted were: Warren S. Rehm, M.D., professor of biophysics and acting chairman of the department of physiology, to chairman; Adolph B. Loveman, M.D., associate professor of dermatology, to chief of the section on dermatology, replacing Winston Rutledge, M.D., who resigned; and Roy S. Griffiths, M.D., research associate to assistant professor of medical psychology (research) in the department of psychiatry.

John F. Ice, M.D., assistant professor of psychiatry, and Letitia S. Kimsey, M.D., associate professor of microbiology, were given additional appointments as associates in child health in the department of pediatrics.

Resignations were accepted from: William C. Wolfe, M.D., chief of the section on otorhinolaryngology in the department of surgery; Thomas Stevenson, M.D., assistant professor of medicine; William J. Brown, M.D., instructor in otolaryngology; Mrs. Norma C. McMahan, lecturer in medical-records library science; Ray H. Hayes, M.D., instructor in psychiatry, and Miss Ruth Mellor, lecturer in social sciences in the department of psychiatry.

It was also announced that a $16,000 grant had been received from the Avalon Foundation for medical school scholarships.

Another grant of $81,000 was awarded to William A. Brodsky, M.D., professor of experimental medicine. This was an extension of a Public Health Service grant for a two-year study of kidneys.

Calvin A. Lang, M.D., assistant professor of biochemistry, has received a $40,900 grant from the National Science Foundation for the study of cellular respiration in animals.

J. K. Conlan, M.D., has re-located his practice of surgery in Hopkinsville. A graduate of the University of Louisville School of Medicine, Doctor Conlan has practiced in Harlan since 1952.

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Dr. Rumage Attends School For Civil Defense Instructors

William T. Rumage, Jr., M.D., Louisville, attended the Eastern Instructors Civil Defense School, October 16-19 in New York. Doctor Rumage, chairman of the KSMA Committee on Emergency Medical Service, reports that the meeting was primarily concerned with the new Medical Self-Help Program to be started by the state.

Lt. Col. James Dorman, Jr., Louisville, has been appointed by the governor to supervise the program in Kentucky. He will work in cooperation with the KSMA and the Kentucky Board of Education. Each community of 1000 or more people will have a Civil Defense program. The mayor of the community will designate a person to head it and physicians and educators will work with him.

Doctor Rumage further reports that Medical Self-Help Kits will be available here after the first of January 1962.

Lecture Series On Cancer Begins At U. of K.

The first program in a series of lectures under the Cancer Teaching Program of the University of Kentucky College of Medicine will be held November 16. Guest speaker will be Harold F. Parks, Ph. D., professor of Zoology at Cornell University. He will talk on the structure of cells. Attending will be students from the College of Medicine, faculty members, and physicians.

Doctor Parks, a native of Illinois, received his Ph. D. degree from Cornell University in 1950 and accepted a position on the faculty of the Anatomy Department at the University of North Carolina Medical School. From 1954-61 he was on the faculty of the Department of Anatomy of the University of Rochester School of Medicine and Dentistry.

Other news from the U. of K. Medical School includes five new appointments. Robert W. Chamberlin, M.D., presently with the U. S. Army Medical Corps has been appointed Instructor of Pediatrics. Hugh Donoso, M.D., formerly a medical investigator at the Department of Medicine, University of Utah, has been appointed Instructor of Medicine. Albert J. Lott, Ph. D. presently Associate Professor of Psychology with the U. of K. College of Arts and Sciences, has been appointed Associate Professor of Behavioral Science, part-time.

Kenneth Boyd Moore, M.D., presently Director of Research and Education at the Veterans Administration Hospital, Lexington, has been appointed Assistant Professor of Clinical Psychiatry. Charles I. Schwartz, M.D., presently Director of Professional Services at the V. A. Hospital, Lexington, has also been appointed Assistant Professor of Clinical Psychiatry.

More new members of the faculty are: Roswell H. Fine, M.D., department of psychiatry, who was previously assistant superintendent of the Sonora State Hospital, California; Michael J. McNamara, M.D., who limits his practice to epidemiology, medical virology, and internal medicine; Frank Cole Spencer, M.D., whose primary interest is cardiovascular surgery; Beverley T. Mead, M.D, with the department of psychiatry, previously with the University of Utah Medical School; James T. Packer, M.D., with the department of pathology.

Kenneth W. Dumars, Jr., M.D, assistant professor of pediatrics, has been appointed medical director of Cardinal Hill Convalescent Hospital The hospital's board of managers in announcing the appointment also stated that this is the beginning of a joint endeavor between the Kentucky Society for Crippled Children which owns the hospital and the U. of K. Medical Center, and also marks the first step toward a new and expanded program for the hospital.

Program Being Developed For Preventing Blindness

The Kentucky Society for the Prevention of Blindness, one of the many state divisions of the National Society for the Prevention of Blindness, recently opened an office at Children's Hospital in Louisville. Their one purpose—saving sight!

The Kentucky Society is developing a comprehensive program directed toward educating the people of the Commonwealth in the prevention of blindness. This they plan to do by serving as a source of public information on all phases of a prevention of blindness program; by sponsoring complete preschool vision screening throughout Kentucky; by accelerating safety programs in all Kentucky schools; by conducting public screening for glaucoma; by establishing Wise Owl Clubs in Kentucky industrial plants; and by participation and assistance in the program of research at the Department of Ophthalmology, School of Medicine, University of Louisville.

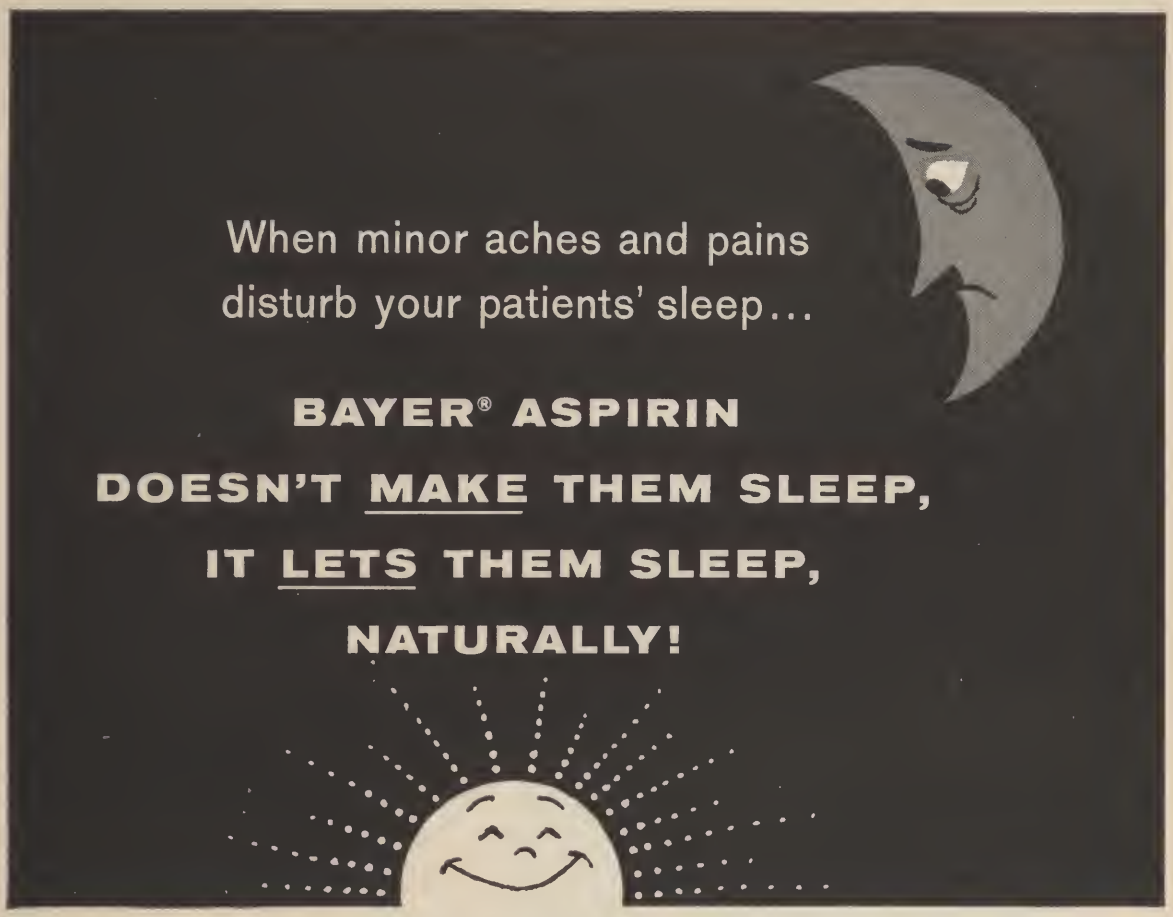
C. Dwight Townes, M.D., is chairman of the Professional advisory committee, which also includes Arthur H. Keeney, M.D., and Roderick Macdonald, M.D. Mrs. Edgar B. Read is the executive director.

Hospital Group Elects Ruskjer

S. A. Ruskjer has been elected first vice president of the 4,500 member American College of Hospital Administrators. Mr. Ruskjer, formerly administrator of Waverly Hills Tuberculosis Sanatorium, is also a member of the Blue Shield Board. He is now serving as director of hospital administration for the Kentucky-Tennessee Conference of Seventh-Day Adventists and is a consultant to the Kentucky State Tuberculosis Hospital Commission.

Dr. Neustadt Speaks In Rome

David H. Neustadt, M.D., Louisville, recently spoke at the International Congress on Rheumatic Diseases in Rome, Italy. He gave a paper entitled, "Clinical Trials of a New Drug." Doctor Neustadt is presently head of the Louisville General Hospital's arthritis clinic.



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Dependents of Servicemen Advised By Medicare

Several hundred servicemen in Kentucky have had their tour of active duty extended beyond the normal date. This extension of duty may result in some dependents being without a valid identification card which is required for the "Medicare" program in Kentucky.

Brigadier General W. S. Graham, executive director of the Office for Dependent's Medical Care, said that "these dependents are being advised that it is their responsibility to take necessary action to 'up date' the dependent's eligibility."

He added, however, that some dependents will need authorized civilian medical care prior to the time this action has been completed. In such cases the dependent should explain the situation to the physician and hospital authorities and present, if available, some tangible evidence such as allotment checks, official orders, or directives.

Drs. Gray, Kotcher Talk In Vienna

The Third Congress of the International Federation of Gynecologists and Obstetricians in Vienna was attended by Laman A. Gray, M.D., and Emil Kotcher, Sc.D., both of Louisville. Together, on September 5, they presented a paper on "Microbiology of Vaginitis—Virological Isolations." Doctor Gray also spoke on "Vaginal Hysterectomy and Plastic Vaginal Repair With Particular Reference to Pre- and Post-Operative Urinary Tract Complaints, Complications and Special Operative Procedures."

Today's Savings Bonds Offer Investment Opportunities

Improvements added to the U. S. Treasury's Savings Bonds program since 1952 have made them steadily more attractive. They now have the shortest maturing period in their history—seven years and nine months—the highest interest rate—3¾ per cent, compounded semi-annually—and have the privilege of a 10-year extension period after maturity.

Also introduced in 1952 were the current-income Series H Bonds. Available in denominations of $500, $1,000, $5,000, and $10,000, they pay an average return of 3¾ per cent twice a year. These bonds may be converted to cash any time after six months' holding, on one month's notice. E Bonds may now be exchanged for H Bonds in units of $500 or more, under terms announced in 1959. Accumulated interest on E Bonds need not be declared for federal income tax purposes until the H Bonds obtained in exchange mature, are cashed, or are otherwise disposed of.

From its beginning, the Savings Bonds program has been tailored for the small saver and investor. For that reason, an annual purchase limitation has been set of $10,000, face value, for both E and H Bonds. Through the use of the co-ownership feature, however, a buyer may purchase limit amounts in various "name" combinations each year, in either or both series.

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ANOTHER YEAR OF SYMPOSIA . . .

PROVIDENCE, RHODE ISLAND
Wednesday, November 1, 1961
The Colony Motor Hotel

HARRISBURG, PENNSYLVANIA
Thursday, November 9, 1961
The Penn Harris Hotel

JACKSONVILLE, FLORIDA
Sunday, November 12, 1961
The Robert Meyer Hotel

ALLENTOWN, PENNSYLVANIA
Wednesday, November 15, 1961
The Americus Hotel

SOMERVILLE, NEW JERSEY
Thursday, November 16, 1961
The Far Hills Inn

NASHVILLE, TENNESSEE
Wednesday, November 29, 1961
Meharry Medical College

EDINBURG, TEXAS
Saturday, December 2, 1961
The Echo Motor Hotel

WACO, TEXAS
Sunday, December 10, 1961
The Holiday Inn

Plans for 1962 already include the following Symposia, with more being arranged:

MOBILE, ALABAMA
Friday, January 5, 1962
The Admiral Semmes Hotel

ST. PAUL, MINNESOTA
January 8, 1962
The Hotel Lowry

PORTLAND, OREGON
Wednesday, January 24, 1962
The Sheraton-Portland Hotel

ANCHORAGE, ALASKA
Saturday, February 24, 1962
The Westward Hotel

WINCHESTER, VIRGINIA
Wednesday, March 14, 1962
The Lee-Jackson Hotel

SIOUX CITY, IOWA
Thursday, March 15, 1962
The Sheraton-Martin Hotel

SPOKANE, WASHINGTON
Saturday, June 2, 1962
The Davenport Hotel

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Plan now to attend the A.M.A. Clinical Session in Denver, November 27-30.

Student AMA

The choosing of the school in which one wishes to study medicine is an important task to perform and one which must be carefully done. Of almost equal importance to the man completing his formal student career, is the choosing of the hospital in which he will intern and perhaps do his resident training. Due to the rapid progress of medicine in the past few years, the internship has become a year of extra opportunity to further keep abreast of this progress as well as a year in which the New Physician might learn to assume more completely the responsibility which will be entrusted him as an M.D.

Realizing the need for a successful internship from the viewpoint of a learning opportunity as well as medical maturity, the young doctor is eager to spend his time in a hospital which will add to the wealth of knowledge obtained in medical school, and which will strengthen his confidence in his ability to practice medicine well. For the most part, these criteria are best met in the larger medical centers, and particularly in hospitals affiliated closely with a medical school. Their program is designed to function around a teaching unit; their patient load affords the maximum of diagnostic problems and allows the intern much of the responsibility in caring for these patients. From these hospitals and institutions also come new ideas in research and new ideas in treating old diseases, so that the intern has a first hand look at much new medical knowledge. With these factors as stated, it would seem that new medical graduates would find their choice of an internship to be a teaching hospital, either their own, or that of another medical school or center.

Such, however, is far from being the case. While many graduates do go to teaching hospitals, many more enter private institutions or smaller hospitals and although these do have fully accredited internships, they do not offer to the young doctor the full measure of teaching which is found in the hospitals affiliated with centers or medical schools. There are no doubt many reasons why this condition should exist, but the chief one seems quite clear. For several years, the young graduate has struggled to keep from sinking into a financial abyss. He has been a constant drain on his family, has lived a meager and budgeted life, and has continually denied his family and himself many of the common luxuries of his neighbor in order that he might succeed in achieving the goal he has set for himself. Now at last he is an M.D. and the opportunity arises for him to reap, financially, some of the rewards of his labor. Private institutions offer from three to six times the salary of teaching hospitals, provide more fringe benefits and supply comfortable and adequate living quarters commensurate with what the new physician feels is his status. There is no puzzlement then, when one wonders why more and more the young doctor goes elsewhere for his internship.

Many points of view are held about this problem—both pro and con. Many feel that the internship is a teaching period also and therefore no remuneration should be given. From the graduate's point of view, however, this opinion is archaic and hence the result as soon seen above. Teaching centers could most certainly alleviate this condition by raising the salary paid to interns and residents, and providing for them more adequate standards of living. It should be remembered that the intern has an obligation to his wife and children as well as to his profession and his patients. We are taught that medicine is based on the best laws of humanity and human kindness in an effort to encourage the betterment of mankind. Is it too much to ask, then, that the intern be able to reap some of the "betterment" which he so ardently is seeking to aid?

Olson Huff
President, U. of L. Chapter

Regional Student AMA Meets

The University of Kentucky Chapter of the Student AMA was host to the Regional Student AMA Convention held in Lexington October 26, 27, and 28. Approximately 50 delegates representing 11 schools attended.

Richard H. Segnitz, M.D., Lexington, is the KSMA member of the advisory committee to the U. of K. chapter. Joe Christian, a sophomore at the Medical School is president. A report of the meeting will appear in the December issue of The Journal of KSMA.

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KAGP Holds Seminars At Three Sites

Four speakers participated in the KAGP's Third Annual Maysville Seminar held on October 19. George E. Estill, M.D., Maysville, was chairman. There were four speakers.

Approximately 55 people were expected to attend the Cave Area Seminar on October 25. Senator Thruston B. Morton was the dinner speaker. John C. Ayers, Jr., M.D., Cave City, was chairman of the Seminar. Four guest speakers participated in the program.

On November 9, the Ashland Seminar was held with C. Wayne Franz, M.D., Ashland, as chairman, and Charles A. Webb, M.D., as moderator. Rudolph J. Muelling, M.D., Lexington, who presented a paper on "Toxicology," was among the program participants.

Fall Clinical Conference Held

The Sixth Annual Fall Clinical Conference, co-sponsored by the Lexington Clinic and the Kentucky Academy of General Practice, was held at the Campbell House in Lexington, October 27. The Lexington Clinic announces that the program was approved for six hours of Category I Credit by the AAGP.

The name of Richard H. Segnitz, M.D., Lexington, was inadvertently omitted from the program of the Conference which appeared in the September issue of *The Journal*. Doctor Segnitz was co-author of a paper on "Surgical Treatment of Congenital Heart Disease: What, When and Where."

Travel Council Organized By KCC

In an effort to promote, develop, protect and encourage travel in Kentucky, the Kentucky Chamber of Commerce has created the Kentucky Travel Council. According to Alex S. Chamberlain, Council Chairman, special emphasis will be put on attracting visitors from out of state.

Official launching of the Council came during the KCC Day ceremonies at the Kentucky State Fair in September. State Chamber President Smith D. Broadbent, Jr., Cadiz, announced the appointment of the Council's Board of Trustees and the selection of Paul W. Grubbs, Louisville, as Director. Mr. Grubbs is Travel Promotion Director for the C. of C.

Campbell Uses X-Ray Trailer

An X-ray trailer donated by the Benevolent and Protective Order of Elks for use in Campbell and surrounding counties was put to use in Campbell County from September 29-October 6. The Campbell County Health Department urged all persons age 20 and over to visit the trailer. Those under 20 were urged to visit the health department or their physician for skin tests to determine whether or not they should be x-rayed.

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Chlorpheniramine maleate 2 mg.—an antihistamine to shrink engorged membranes and lessen rhinorrhea

Ascorbic acid (vitamin C) 50 mg.—to increase resistance to infections†

New Win-Codin tablets will bring more comfort to many patients suffering from severe colds, influenza or sinusitis.

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IN THE BOOKS



KEY AND CONWELL'S MANAGEMENT OF FRACTURES, DISLOCATIONS AND SPRAINS, Seventh Edition: by H. Earle Conwell, M.D., F.A.C.S., and Fred C. Reynolds, M.D.; published by The C. V. Mosby Company, St. Louis, Mo.; 1153 pages; price, $27.00.

The most recent edition of this treatise on musculoskeletal injuries maintains the high standards of its predecessors.

Its format remains essentially the same. The first portion of the book deals with principles and general aspects of the subject. The major part, however, is the consideration of specific injuries on a regional basis.

In Part I there are adequate discussions of first aid and emergency treatment, diagnosis of fractures and dislocations, and x-ray examinations. Equipment necessary for adequate treatment and plaster of Paris technique are also described. Of special interests and importance are the chapters on repair of fractures, principles of fracture treatment and complications of fractures. A section on anesthesia for patients with musculo-skeletal injuries is presented by the Professor of Anesthesiology of Washington University School of Medicine.

Each chapter on regional injuries contains a pertinent discussion of the surgical anatomy, methods of examination and differential diagnosis. Different types of treatment for most injuries are described, usually with the advantages and disadvantages or complications associated with each.

The chapter on Injuries of the Hand has been revised (by Dr. A. H. Stein, Jr., Assistant Professor of Orthopedic Surgery, Washington University School of Medicine), and discussions on the use of intramedullary fixation and hip prosthesis are included. The section of spinal injuries, including cord and disc lesions and whip-lash injuries has been considerably enlarged.

The text is clear, and there are many pictures, diagrams and well-produced x-ray plates. The authors are to be commended for their conservative attitude and for emphasizing the complications of inadequate or improper treatment.

This edition is a memorial to the late J. Albert Key, M.D. The present co-author, Dr. Fred C. Reynolds, apparently is a worthy successor.

Charles F. Wood, M.D.

ATLAS OF OBSTETRIC TECHNIC: by J. Robert Willson, M.D., M.S.; published by The C. V. Mosby Company, St. Louis, Mo.; 304 pages; price, $14.50.

The value of this book is best expressed by Doctor Willson in his preface. Whereas there are several textbooks and atlases devoted exclusively to descriptions of operations in gynecology and other branches of surgery, there are no such books devoted exclusively to obstetrical techniques. The various obstetrical textbooks are so voluminous that there is no room for a description of the various obstetrical operations with complete illustrations of all steps in the procedure.

This void Doctor Willson has sought to fill in his book. The professional hospital staff and the labor and delivery room facilities are described in the first chapter. Thirty-seven pages are then devoted to a description of normal labor and delivery, according to the author's practice.

The remainder of the book consists of diagrammatic illustrations and the description of the technique and management of the various obstetrical operations—forceps, breech delivery, Caesarean Section, mal presentations and positions, and a final chapter describing craniotomy.

The book is recommended as a reference book for the practitioner who already has a good knowledge of pelvic anatomy, and who has the ability to diagnose various abnormalities. He also must have complete knowledge of the mechanism of labor.

The atlas serves as a supplement to a complete obstetrical textbook, and as the author emphasizes, it is not a substitute for a standard textbook. The pictures are exceptionally clear with excellent description, and the book is a welcome addition to the medical library.

Silas H. Starr, M.D.

SYMPTOM DIAGNOSIS: by Wallace Mason Yater, M.D., F.A.C.P., and William Francis Oliver, M.D., F.A.C.P.; published by Appleton-Century-Crofts, Inc., New York; fifth edition, 1047 pages; price $15.00.

This book is not one that can be read from cover to cover. It is strictly a reference type of book, designed by the authors for use in a situation in which a physician may wish to know all the known causes of a particular symptom. It is an especially useful source of information when one desires to know the less common or rare causes of a specific symptom.

The organization of this book is excellent. It is organized in two primary sections—(1) Regional Symptoms and (2) General Symptoms.

The regional symptoms section is divided into Anatomical Divisions beginning with the head and ending with the toe. At the beginning of each division there is a list of symptoms relative to that particular region of the body which is to be discussed in detail in this chapter. For example, the first chap-

ter is on the head and some 25 different symptoms are discussed in detail. There are separate chapters on the face, eye, ear, nose, lips, mouth, teeth, tongue, throat which are not discussed in the section on head.

Following the section on regional symptoms there is a section devoted to general symptoms not related to any particular anatomical section of the body, such as low blood pressure, coma, weight loss, anemia, anaraxia, etc.

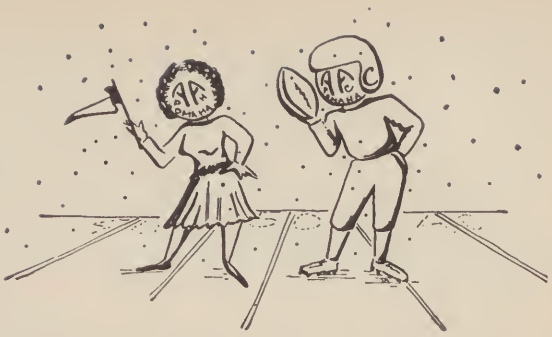
There are in this book eighteen (18) differential diagnosis tables which are very useful especially in a difficult clinical situation.

In the appendix of this book there is a list of syndromes and diseases with symptoms and signs associated with men's names. I believe this is the only place I have seen this type of information recorded in one place.

I feel that this book is a very worthwhile book to have in any medical library or on any physician's desk.

Samuel M. Smith, Jr., M.D.

Officials of the State Tuberculosis Hospital Commission have announced the appointment of **Orion W. Harris, M.D.**, as Medical Director of the District 6 State Tuberculosis Hospital, Glasgow. He succeeds **Nicholas S. Russinovich, M.D. Luigi Pacini, M.D.**, Assistant Medical Director for the past several months, will continue in that capacity. Doctor Harris, a Scottsville native, has been Assistant Medical Director of the District 1 Hospital in Madisonville.



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Auxiliary Extends Nursing Grant

The Woman's Auxiliary to the Fayette County Medical Society has extended its scholarship program to enable a hospital nursing graduate to complete degree work at the University of Kentucky College of Nursing. According to Dean Marcia Dake of the College of Nursing, this is the first scholarship at U. of K. for a registered nurse enrolled in the College, and will enable her to complete her bachelor of science degree in a shorter period of time.

Mrs. T. Rothrock Miller, chairman of the auxiliary's scholarship committee has announced that Mrs. Clara Thomas, supervisor of pediatric nursing and instructor in care of children at Good Samaritan Hospital, Lexington, has been selected to receive the scholarship.

Mrs. Morford Honored

Mrs. Guy Morford, Owensboro, newly installed president of the KSMA Woman's Auxiliary was honored at a luncheon given by the Auxiliary to the Pulaski County Medical Society. The luncheon was held at a meeting of the 12th District Auxiliaries on October 19. Members and members-at-large from eight County Medical Auxiliaries were invited to attend.

Mason County Auxiliary Meets

At their September meeting, members of the Woman's Auxiliary to the Mason County Medical Society decided to re-subscribe to "Today's Health." The subscriptions are distributed to the libraries of the Mason County, Maysville, and St. Patrick high schools. The president of the auxiliary, Mrs. J. E. McKinney, presided at the meeting.

Jefferson County Office Moved

An open house was held October 16 by the Jefferson County Medical Society after moving its offices to larger quarters within the Medical Arts Building, Louisville. The day was highlighted by a blood donor project, a movie on oral polio vaccine, a social hour and dinner, and concluded with a business meeting. The dinner speaker was Robert A. Hingson, Cleveland, Ohio, who spoke on "The Challenge of Asia and Africa to Physicians of All Specialties in Our Generation."

Gerald H. McCord, M.D., who has practiced for a year at Providence in association with **Paul Taylor, M.D.**, has moved to Hopkinsville where he will occupy the office of **Gabe A. Payne, Jr., M.D.** Doctor Payne has moved to Nashville where he is taking a year of residency and study at Vanderbilt University School of Medicine.

H. B. Murray, M.D., West Liberty, has been appointed by Gov. Bert T. Combs as a member of the Advisory Board of Aeronautics. Doctor Murray has held a pilot's license since 1946 and was a flight surgeon with the Air Force during World War II.

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In brief

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*Jacques, A. A., and Fuchs, V. H.: J. Louisiana M. Soc. 113:200, May, 1961.

In Memoriam

DAVID A. BATES, M.D.
Shepherdsville
1882-1961

David A. Bates, M.D., formerly a physician in the Okolona area, died September 9 at his home in Shepherdsville. A 1908 graduate of the University fo Louisville School of Medicine, Doctor Bates began practice in 1910. He retired in 1959 and moved to Shepherdsville. A member of the Jefferson County School Board from 1936 to 1952, he also served as board chairman for a time.

W. A. CALLIS, M.D.
Scottsville
1873-1961

A retired physician and former Scottsville resident, W. A. Callis, M.D., died September 13 at a Nashville hospital. Doctor Callis, 89, was a Warren County native. He received his medical degree from the University of Louisville in 1903.

ARTHUR D. DONNELLY, M.D.
Bowling Green
1890-1961

A 1916 graduate of the Vanderbilt University School of Medicine, Arthur D. Donnelly, Sr., M.D., died September 13 at his home after a long illness. Doctor Donnelly, a Bowling Green physician for many years, had retired about six years ago.

LONNIE D. HALE, M.D.
Murray
1881-1961

Lonnie D. Hale, M.D., died September 20 at the Murray Hospital following a six-week illness. Doctor Hale, a 1913 graduate of the St. Louis College of Physicians and Surgeons, had retired several years ago. A native of the county, he was also a lifetime member of Calloway County Medical Society.

WILLIAM L. MORSE, M.D.
Earlington
1877-1961

William Livingston Morse, M.D., a retired Earlington physician, died at his home on October 17. He was 83. Doctor Morse, a native of Caldwell, received his medical degree from the medical department of the University of Louisville in 1913. Carlisle Morse, M.D., Louisville, is a son.

SAMUEL M. RICHIE, M.D.
Hazard
1877-1961

A physician for over half a century, Samuel M. Richie, M.D., died September 29 in Hazard. Doctor Richie was born in Perry County and received his medical degree from the Hospital College of Medicine, Louisville, in 1905. He practiced in Hazard and Perry County and other parts of southeast Kentucky. He was 85 and had retired from medical practice in 1956.

JOHN D. WILLIAMS, M.D.
Ashland
1872-1961

A native of Boyd County, John D. Williams, M.D., died September 8 in Pleasant View Manor, Huntington, W. Va. Death was caused by a brain injury he suffered in a fall in October 1960.

Doctor Williams received his medical degree in 1895 from Miami Medical College in Cincinnati. He did postgraduate medical study in other schools and in New York, Vienna, Berlin and London. He was certified by the American Board of Otolaryngology and was a fellow of the American College of Surgeons. His practice was begun in Catlettsburg where he was also active in civic and educational affairs.

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From the files of the
COMMITTEE FOR THE
STUDY OF MATERNAL MORTALITY



CASE #91—A 30-year-old white gravida 8, para 5, whose expected date of delivery was July 21, 1960, first consulted her physician at six months of pregnancy. The past history was negative, apart from a dilatation and curettage performed in 1958. The hemoglobin was 11 grams per cent; serologic tests for syphilis were negative; the patient was Rh positive.

Month	Month of Pregnancy 1 2 3 4 5 6	7	8	9	
Date	4-25		6-6	6-20	7-9
Blood Pressure	116		118	116	116
	70		70	70	70
Weight	188½		190¼	192	186
Urine	Neg		2+ alb.	Neg	2+ alb.

The prenatal course was uneventful until the eighth month of pregnancy, when ankle edema and albuminuria of moderate degree were noted. However, according to the protocol, this was not treated.

At 2:00 p.m., July 9, 1960, the patient began having irregular uterine contractions, occurring every 15 minutes. On vaginal examination the cervix was firm, uneffaced and undilated. The presenting part was unengaged. The contractions gradually increased in frequency, and she was admitted to the hospital at 9:35 p.m. of the same day with 5 to 7 minute mild contractions. Examination at this time revealed no change in the pelvic findings.

During the evening the contractions became irregular. The patient was given one minim of pitocin subcutaneously at 1:00 a.m., July 10. Within ten minutes she began having hard contractions every two to three minutes. Repeat examination revealed no change in the pelvic findings. The membranes ruptured spontaneously at 1:52 a.m., accompanied by the passage of a large amount of thick amniotic fluid. The blood pressure was 110/80. The fetal heart was 144 and regular. The patient was given Demerol 50 milligrams and Scopolomine 1/300 grain at 2:00 a.m. because of severe abdominal pain. Rectal examination at 3:00 a.m. showed no change in the pelvic findings, the cervix remaining uneffaced and undilated, and the head unengaged in the pelvis.

At 3:30 a.m., the patient suddenly became dyspneic, restless and cold, and began perspiring profusely. The blood pressure was unobtainable and the pulse was very rapid and thready. The fetal heart could no longer be heard. On vaginal examination moderate bleeding was noted. The cervix was still uneffaced and undilated and the presenting part was unengaged. The patient was given oxygen but due to her restlessness it had to be discontinued. Blood was drawn for typing and crossmatching, and an intravenous infusion of Dextran was started. Her blood pressure remained unobtainable. At 4:45 a.m. an emergency laparotomy was performed while Dextran and blood were both being administered. During the laparotomy the blood pressure remained unobtainable, the patient's respirations were rapid and gasping, and her condition was critical.

At laparotomy, a massive hemoperitoneum was noted, secondary to an extensive rupture of the uterus in the posterior wall extending from the infundibulopelvic ligament on one side to the ovarian ligament on the opposite. An interstitial myoma six centimeters in size was present immediately adjacent to the rupture in the posterior uterine wall. A moderately large hematoma was present in the left infundibulopelvic ligament.

A stillborn female infant, weighing seven pounds, two ounces, had been extruded into the abdomen and was removed with the placenta. The uterine rupture was closed with three layers of chromic catgut. At the completion of the surgery, the patient was pulseless. She was pronounced dead at 5:20 a.m.

The cause of death as stated on the certificate was spontaneous rupture of a gravid undelivered pregnancy.

Comments

The committee classified this case as a direct obstetrical death with preventable factors. The symptoms of ankle edema and albuminuria should have been treated, even though this did not contribute directly to the patient's death.

Rupture of the gravid uterus is one of the most serious complications of pregnancy. Often there is a history of trauma, or previous surgery such as dilatation and curettage with unsuspected uterine perforation. The woman who has delivered five or more infants is especially susceptible to this complication. Therefore oxytocic stimulation of labor should not be used in these patients; or if utilized, the greatest degree of caution should be exercised. At no time should pitocin be administered to any patient in whom the presenting part is unengaged.

According to the protocol, there was a two hour interval from the time that the pitocin was administered until the uterine rupture was recognized. A further hour and fifteen minutes elapsed until the surgery was begun. This time factor no doubt greatly contributed to the patient's death.



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Pyrilamine Maleate		12.5 mg.
Phenylephrine Hydrochloride		10 mg.
Ammonium Chloride		60 mg.
Sodium Citrate		85 mg.

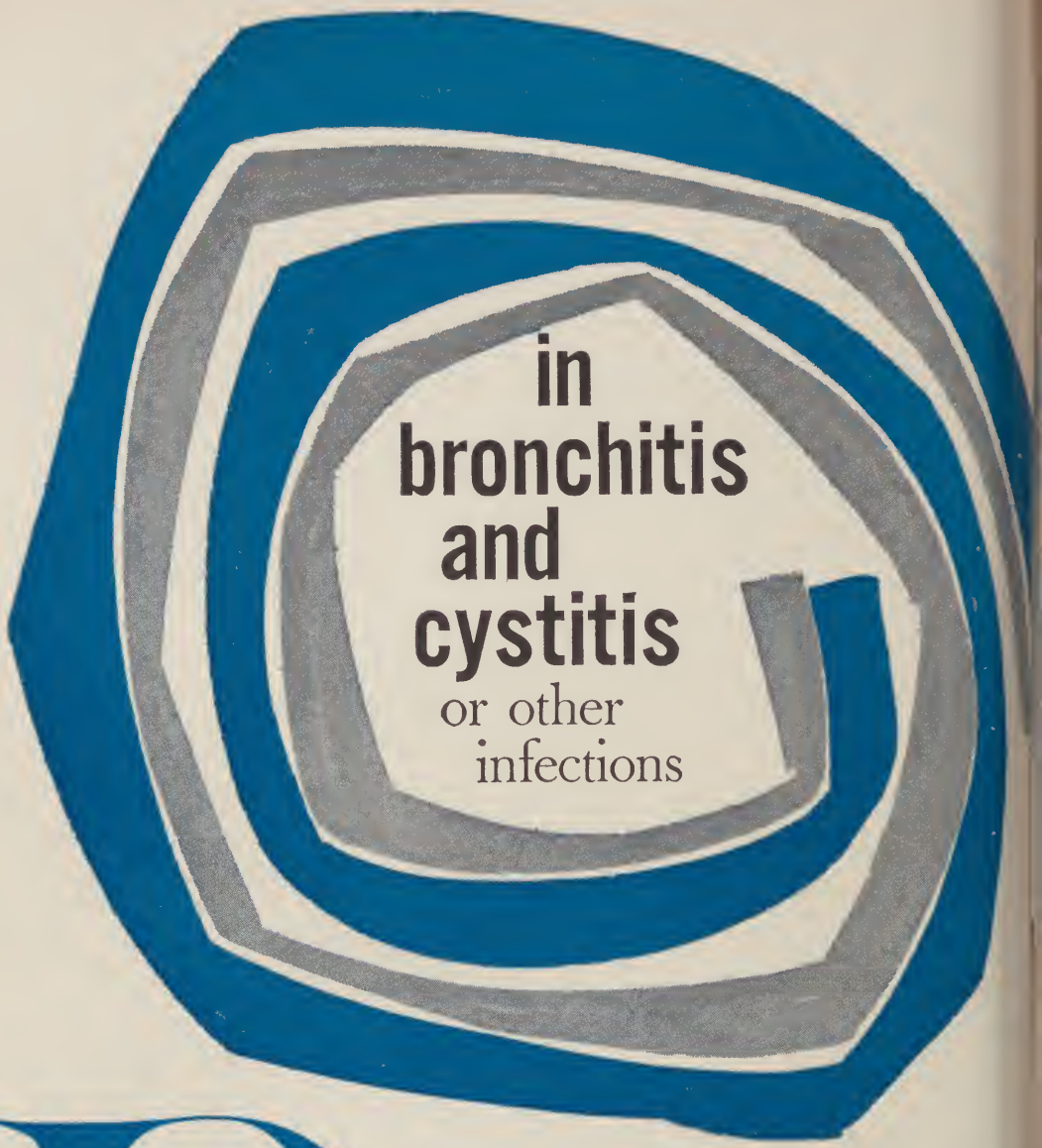
Average adult dose: One teaspoonful after meals and at bedtime. May be habit-forming. Federal law permits oral prescription.

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Overgrowth of nonsusceptible organisms is a possibility with DECLOMYCIN, as with other antibiotics, and demands that the patient be kept under constant observation.

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Q.—Is treatment of burns considered a surgical procedure by Blue Shield?

A.—Yes. Allowances for burns are given individual consideration. It is important for the doctor to describe the location, extent, and degree of the burn. Payment is made for the first dressing only. A series of treatments in the doctor's office is not included in the Blue Shield dues structure.

Q.—What are the factors used in determining Blue Shield rates?

A.—They are determined by type of contract as follows:

1. Costs of services paid for by Blue Shield and their trend.
2. Usage by members.
3. Overhead costs of operation.
4. Establishment of reserves as required by the State Insurance Commission and the National Association of Blue Shield Plans to insure ability to meet emergencies.

Q.—My father died and he had just made a payment for Blue Shield dues for 3 months. How do I get a refund for the period of 2 months that protection was paid for after he died?

A.—If your mother is still living, give Blue Shield the date of the father's death, his name and certificate number and the mother's name and address and indicate that she wants to continue the protection on a single basis. Otherwise, give the same information about the father and request a refund for the period paid for after his death.

Q.—My company has Workmans Compensation and also Blue Shield. I was injured on the job. The company wanted me to have the Doctor submit his claim to Blue Shield and not report it as a Workmans Compensation case. Is this legal and the right thing to do?

A.—Blue Shield excludes payment for Workmans Compensation cases, because employers are required by Law to carry Workmans Compensation Insurance and members do not pay for on the job injury in their dues. Falsification of these cases is unjust to Blue Shield and to it's members and is illegal, (and not the right thing to do.)

Q.—What is considered a related condition by Blue Shield?

A.—Any condition related to the diagnosis. Any service performed for such condition falls under the "related condition" provisions. For instance, after a diagnosis of carcinoma, any surgery (such as prophylactic hysterectomy) or any x-ray treatment for carcinoma in the same or other parts of the body are considered to be treatment for a related condition.

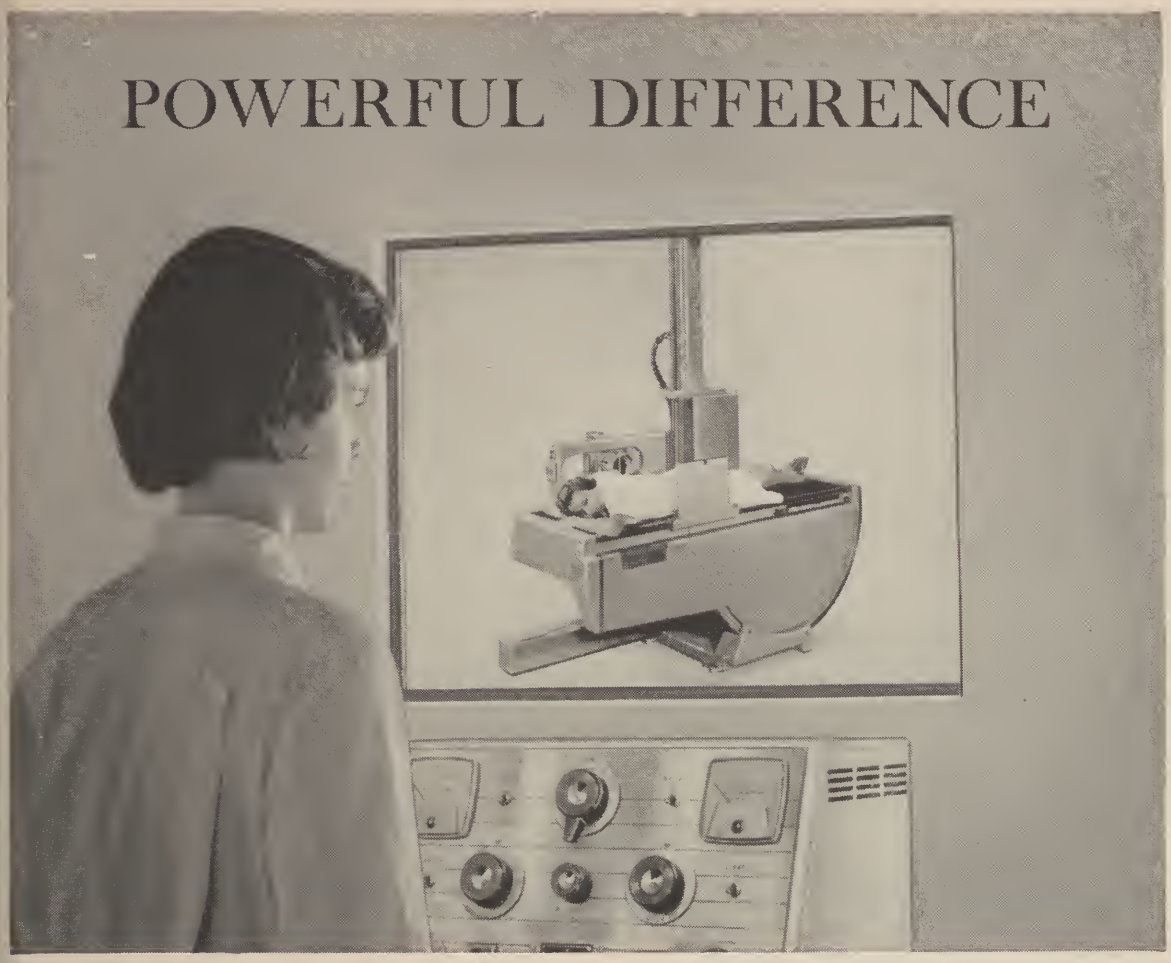
Q.—A member asked as follows: "It says in my contract that Blue Shield will pay up to $15 for accident x-rays. I just received my notice from Blue Cross where they paid the hospital bill on my accident. There is an unpaid balance of $15.00 for x-rays. I want to know why the x-ray was not paid.

A.—Accident x-rays are a professional service not provided by Blue Cross. Our records indicate that we have not received a report from the hospital for your x-rays. If you would please contact your doctor or the hospital and have a *Blue Shield* service report sent to Blue Shield signed by the doctor the claim will then be processed, or forward a paid receipt for the x-ray and reimbursement will be made directly to you.

Q.—What is included in Obstetrical Services?

A.—Obstetrical services (including miscarriage, ectopic pregnancy, delivery or any other service required due to pregnancy) are those rendered by the doctor of Medicine in charge of the case. BUT NOT UNTIL A FAMILY CONTRACT HAS BEEN IN FORCE NINE CONSECUTIVE MONTHS.

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1. Clark, T. E., and Jochem, G. G.: Angiology 11:361 (Aug.) 1960.

*brand of hydroxyzine **pentaerythritol tetranitrate

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YOUR RESULTS: With pain relieved, stiffness gone, your patient is soon restored to full activity—often in days instead of weeks.

Kestler reports in controlled study: *Average time for restoring patients to full activity: with Soma, 11.5 days; without Soma, 41 days.* (*J.A.M.A. Vol. 172, No. 18, April 30, 1960.*)

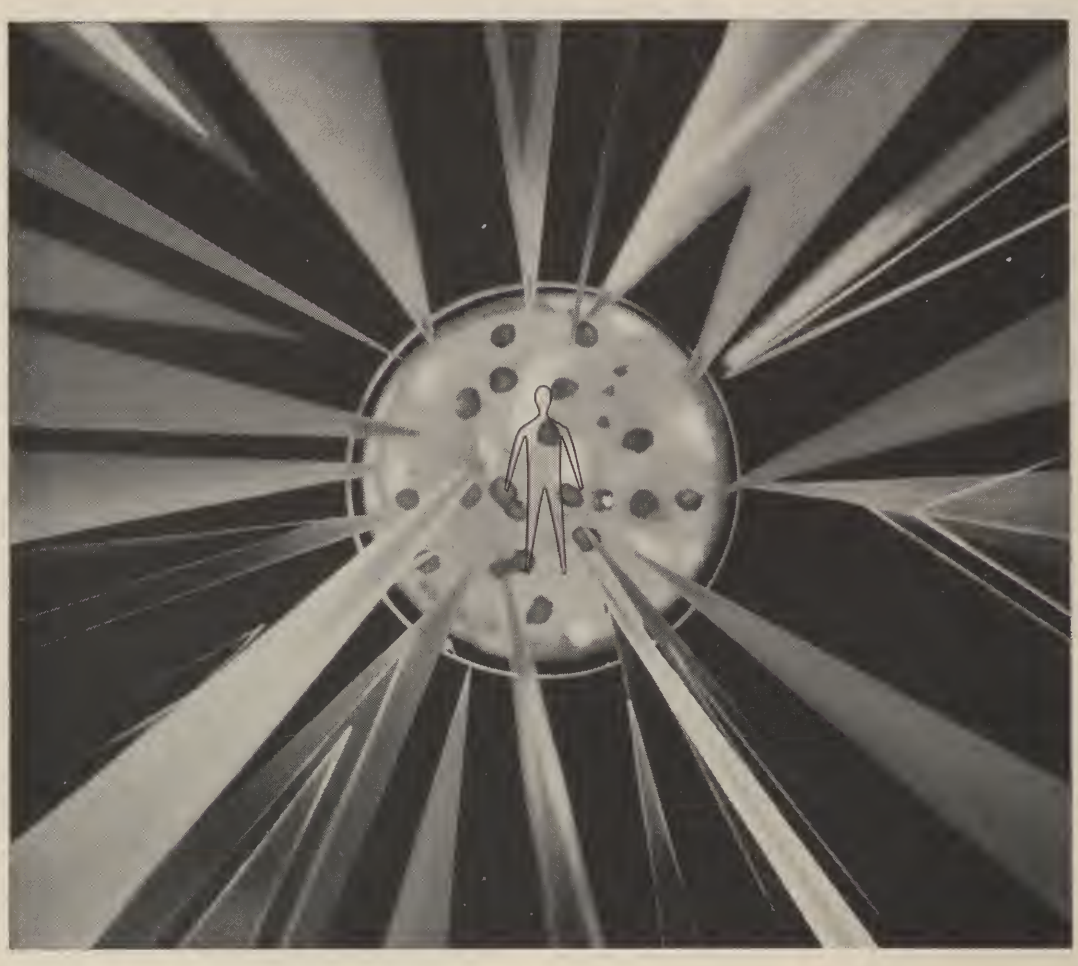
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Available as: Mysteclin-F Capsules (250 mg./50 mg.) Mysteclin-F Half Strength Capsules (125 mg./25 mg.) Mysteclin-F for Syrup (125 mg./25 mg. per 5 cc.) Mysteclin-F for Aqueous Drops (100 mg./20 mg. per cc.)

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PUBLIC HEALTH PAGE

The Fragmentation Of Community Health Services In Kentucky

RUSSELL E. TEAGUE, M.D., M.P.H.

Commissioner of Health
Commonwealth of Kentucky

IN view of the dynamic changes in the practice of medicine, it is asked that the medical profession take a new look at its role in the leadership for community health affairs. They should analyze the health needs and initiate plans for developing services and participating in the administration and operation of such services.

From the struggle that has been waged during the past several years by organized medicine in holding its rightful place in the practice of medicine and community health programs, four significant facts have emerged:

1. Governmentally operated programs have increased in number and extent without the benefit of medical direction.

2. The medical profession has lost its leadership in community health affairs to a degree which is indicated in many states by the withdrawal of support from the health departments' growth and development.

3. The administration of community health services is rapidly being transferred from medically directed to non-medically directed agencies which, in many areas, is largely due to the reluctance of the medical profession and medical health officers in taking the lead in public health programming.

4. The extent that non-medically directed agencies have increased activities in the area of community health services is correlated with facts that services have become fragmented, that the development of quality has been retarded, that the increased emphasis is on payment instead of care, that the cost of administration and operation has increased, and that the performance is plagued with confusion.

In order to have a clear understanding of what we are attempting to examine, let us first define fragmentation as follows: (1) The delegation of responsibility for each specific health program to one of the variety of state and local agencies, thus distributing the responsibilities for various types of health services among these agencies; and, (2) The splintering of administration of a specific health program area among more than one agency, especially at the state level, thus encouraging redundance or duplication in rendering health service by a variety of agencies. In a recent national study which was published in the Journal of the Louisiana State Medical Society,[1] Kentucky was reported to have increased from four different state agencies operating community health programs in 1930 to thirty-one in 1950. This is an increase of 775 per cent in fragmentation. Furthermore, the number of community health programs operated by state agencies other than the State Health Department increased from two in 1930 to thirty-nine in 1950. This is an increase of 1,950 per cent. No data is available in the above-mentioned report for activities since 1950, but a quick review indicates that the fragmentation has significantly increased in Kentucky since 1950. One may say that this has little meaning unless compared with other states. The above-mentioned report shows that during the period 1930 to 1950 Kentucky had a larger degree of fragmentation than all states except Hawaii, both in the number of state agencies operating programs and the number of programs operated by agencies other than the State Health Department.

Without embarking upon a philosophical dissertation on the subject of collective human effort manifest by quantitative growth or recession of society, it can be predicated that society's ability to increase the amount of its health services derived from its general ability to increase its knowledge and technology, on the one hand, and to direct and control quantitatively the application of this knowledge and technology

[1] *Ben Freedman, M.D.; The Fragmentation of Community Health Services in Louisiana: The Responsibility of Organized Medicine; The Journal of the Louisiana State Medical Society, July, 1961—Vol. 113, No. 7, 264-275.*

on the other hand. In the field of health much has been learned in the past century. However, the application of knowledge for enhancing community health has lagged, particularly in the area of research and program development since therapeutic medicine has become a prominent means of medical application. Public health programs have been service oriented basically in the area of communicable disease control and quite limited in the control of environment and in new developmental areas of community health.

The controlling factors in the application of medical knowledge and technology are, in the first place, the interest and support of the community, and secondly, the interest and support of the medical profession. It is suggested that to prevent a continued increase in cost of medical services it will be necessary for the physicians to participate in a positive manner in the planning and developing of community health services, especially those areas where high costs have created the most obvious problems. It is suggested that there is no substitute for medical leadership in meeting community health needs which will inevitably create a "public image" of organized medicine highly favorable to the public, and will certainly reduce the pressures for the development of governmentally organized community health programs, represented in the high degree of fragmentation. It is suggested that the medical profession may be somewhat misled by having physician representation on various boards and advisory committees of non-medically directed agencies, and it is urged that for the good of the citizens of Kentucky and the medical profession there is no substitute for medical leadership in the official state and local health agencies, particularly when this leadership is supported by organized medicine.

Robert J. Wolfe, M.D., a graduate of the University of Louisville School of Medicine, has been appointed a teaching fellow in pathology at Harvard University Medical School. He is affiliated with Massachusetts General Hospital.

A 1960 graduate of the University of Louisville School of Medicine, **John J. McHugh, M.D.**, is taking residency training in pathology at the Louisville Veterans Administration Hospital. Doctor McHugh interned at Louisville General Hospital and served as a first lieutenant with the U. S. Army for four years.

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(1) Danowski, T. S.: Diabetes Mellitus, Baltimore, Willlams & Wilkins, 1957, p. 239. (2) McCune, W. G.: M. Clin. North America 44:1479, 1960. (3) Ackerman, R. F., et al.: Diabetes 7:398, 1958.

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Bibliography: (1) Jacobs, I.: GP *21*:93 (Jan.) 1960. (2) Shulman, I.: J.A.M.A. *175*:118-123 (Jan 14) 1961. (3) Moore, C. V., in Wohl, M. G., and Goodhart, R. S.: Modern Nutrition in Health and Disease, ed. 2, Philadelphia, Lea & Febiger, 1960, p. 243.

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MEDICUS

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References: (1) Malone, F. J., Jr.: *Mil. Med.* 125:836, 1960. (2) Martin, W. J.; Nichols, D. R., & Cook, E. N.: *Proc. Staff Meet. Mayo Clin.* 34:187, 1959. (3) Ullman, A.: *Delaware M. J.* 32:97, 1960. (4) Petersdorf, R. G.; Hook, E. W.; Curtin, J. A., & Grossberg, S. E.: *Bull. Johns Hopkins Hosp.* 108:48, 1961. (5) Jolliff, C. R.; Engelhard, W. E.; Ohlsen, J. R.; Heidrick, P. J., & Cain, J. A.: *Antibiotics & Chemother.* 10: 694, 1960. (6) Lind, H. E.: *Am. J. Proctol.* 11:392, 1960.

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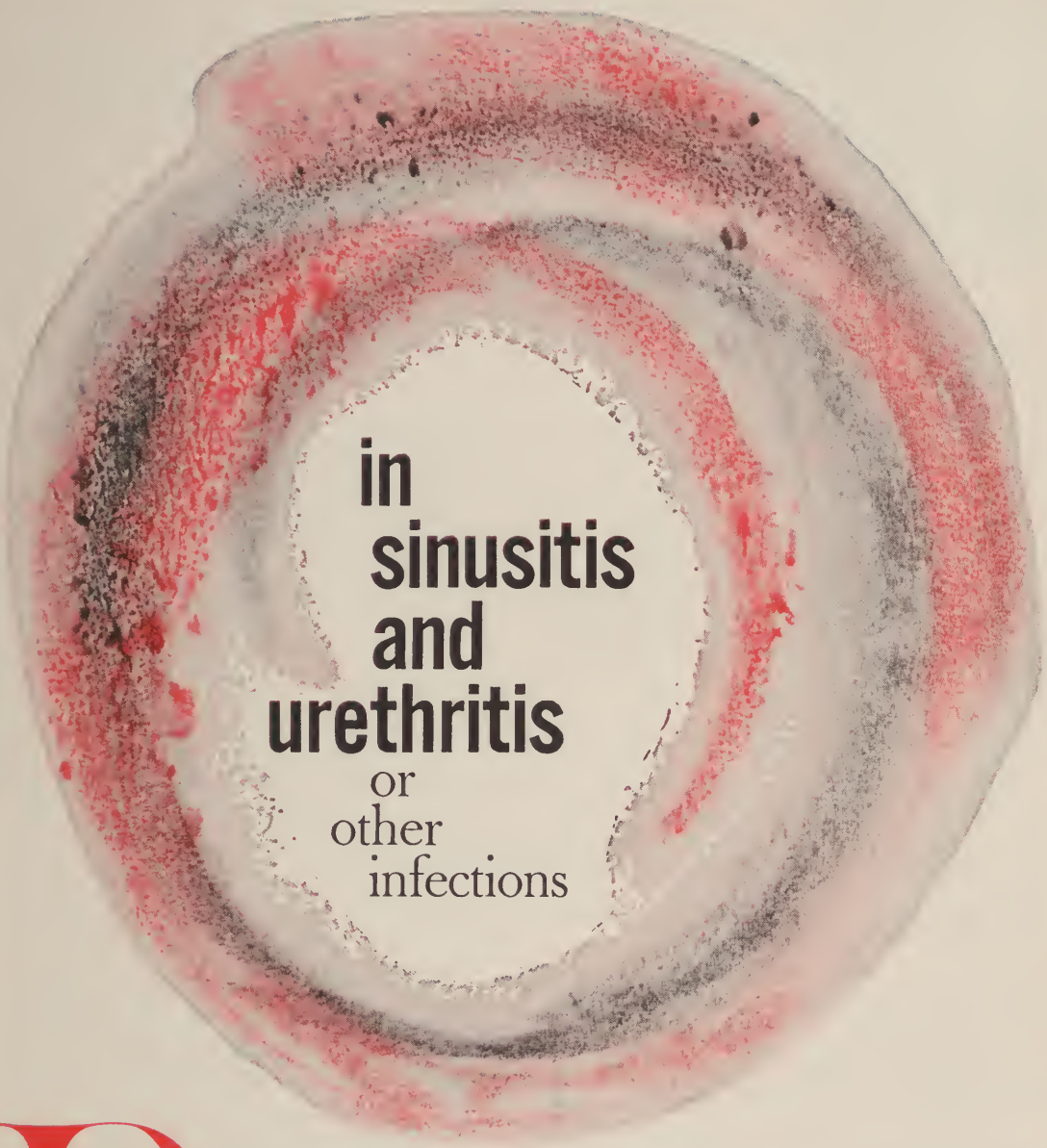
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President's Page

ABRAHAM Lincoln has said "with public sentiment nothing can fail." This public sentiment we must strive for and GAIN.

In today's world, when medical groups are often criticized and misunderstood, it is up to each one of us to realize that these opinions often stem from ignorance of our standards and concepts and we MUST not ignore the importance of telling our own story and telling it well.

Too many people have no realization of the work that the medical profession and we, as doctor's wives, do in the medical auxiliary—the contributions to medical schools through AMEF, dissemination of information through Cancer speech contests, our many scholarships in Health Careers and our safety program.

Sometimes we hear that the image of the medical society, the AMA and the auxiliary is not good. An AMA News editorial says that the word image itself, when modified by "good" or "bad" becomes a symbol of success or failure in PUBLIC RELATIONS—a measure of popularity or the lack of it.

We wonder sometimes why the auxiliary and medical society doesn't get favorable or good publicity from the newspapers and why our write-ups go astray or come out completely made over, sometimes to our discredit. Perhaps we need to analyze our public service efforts.

Professional public relations directors recommend that all organizations need assistance in the development and maintenance of good relations with our many "publics" and to realize the importance of a sound and properly planned program to build good public service programs. Organizations need to know the WHAT, WHO, WHERE, WHEN, and HOW of a public service program and the means by which the general public can become better informed and favorably disposed toward a particular group. These directors suggest that it is only by making good use of all the media available that accurate and essential information can be brought to this public of ours.

Our public relations might be termed the acceptance and approval accorded our organization and all its members by those in other organizations, the community and the nation. Each member is a part of our staff. Her conduct, attitude, achievements and contributions to society present to the public at large an impression of Medical Auxiliary, and each person has a powerful influence on our standing.

The art of public relations is that of analyzing, influencing and interpreting. We must first analyze and determine whether or not our program is a worthwhile one. Secondly, we must plan our activities so that they will be a beneficial influence in our particular community. Thirdly, this program must be interpreted through all the media at our command.

In searching ourselves and our own component auxiliaries for the answers, we need to eliminate our weaknesses and then capitalize on our strength. By so doing, and using every means to "tell our story," the medical profession and the woman's auxiliary will then merit and gain the approval of the public.

Mildred Morford, President
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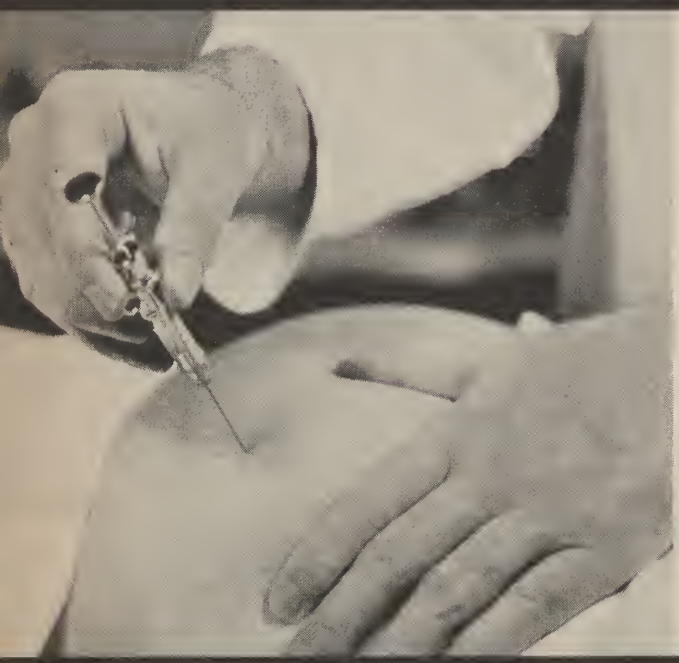
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THE INSURANCE PAGE



Blue Shield and Our Senior Citizens

WHEN our Kentucky Blue Shield Plan was organized, few of those who were covered by it were more than 65 years of age; and they, only because they were included within group contracts.

As the years passed, an increasing number of senior citizens owned Blue Shield contracts. This was due to the fact that Kentucky Physicians Mutual, unlike many private insurance companies, has always allowed anyone who leaves a group to retain his coverage on an individual basis, regardless of age or insurability.

Until quite recently, however, it was not possible for a person past 65, who had not previously been covered by a Blue Shiled contract, to obtain this coverage on an individual basis.

Two years ago, for a limited enrollment period, a special non-group contract was offered to older people of limited income and resources. This offer was made by our Blue Shield Plan in an effort to help solve one of the most pressing problems of our time—the provision of adequate health care to the aged low income group.

A few weeks ago, Kentucky Physicians Mutual, for the first time in its history, removed the age limit on its standard non-group contract, and offered it to individuals of all ages, at the standard premium rates, during a limited enrollment period.

Since insurance of any kind does not create new wealth, but merely pools its funds derived from premium income, it can be readily understood that it was necessary to employ underwriting techniques in selecting those applicants who could be given this coverage. Otherwise, the plan would soon be bankrupted by the sudden heavy influx of applicants having pre-existing disease conditions of which they had long been aware.

On the other hand, there are a large number of older people in currently good health, to whom this new protection will be a real boon.

The physicians of our state have a vitally important role in making it possible for Blue Shield and Blue Cross to open this new coverage. It is only through us that the insurability of those older persons who apply can be determined.

Obviously, a certain amount of work and inconvenience will be placed upon those physicians whose patients have applied for this coverage. Some physicians have expressed concern over the possibility that they may acquire the ill will of those of their patients who are denied coverage because their physicians have attested to the existence of disease conditions which rendered the individual uninsurable.

The validity of these objections on the part of some of our physicians must be recognized. On the other hand, all physicians should be aware that Blue Shield and Blue Cross, through this new offer, will have helped many older people to obtain health care protection which they have long needed.

Surely, each of us should be willing to make some personal sacrifice, to assist as many as possible of our older citizens in obtaining financial security against the costs of illness, without asking that our government provide such security at the tax payer's expense.



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WASHINGTON NEWS DIGEST

WASHINGTON, D. C.—The Public Health Service said that radioactive fallout levels resulting in the United States up until early November from the new series of Soviet nuclear explosions "do not warrant undue public concern" nor initiation of any special public health action.

The federal agency said that the prevailing levels were not high enough for the public to be concerned about the safety of milk and other foodstuffs.

But PHS added that "continuous, intensive surveillance" by federal, state and local governments was justified.

In a special statement issued after a two-day conference of government and private radiation experts, the PHS pointed out that "very little is known about the effects on animals or humans of very low but prolonged exposures" from either natural background radiation or fallout nuclear tests.

"The concensus of scientific opinion is that the most prudent course is to assume there is no level of radiation exposure below which one can be absolutely certain that harmful effects may not occur to at least a few individuals when sufficiently large numbers of people are involved," the PHS said. "This is known as the 'non-threshold' concept."

This concept is the basis for U.S. policies and programs for assessment of radiation hazards and for control measures designed to limit exposures of the population, the PHS said and added:

"When this non-threshold concept is applied to present radiation exposure levels being experienced in the U.S. from all sources, including fallout, the following assessment can be made:

"The extra radiation caused by the Soviet tests will add to the risk of genetic effects in succeeding generations, and possibly to the risk of health damage to some people in the United States. It is not possible to determine how extensive these ill effects will be—nor how many people will be affected. At present radiation levels, and even at somewhat higher levels, the additional risk is slight and very few people will be affected. Nevertheless, if fallout increased substantially, or remained high for a long time, it would become far more important as a potential health hazard in this country and throughout the world.

"It is the obligation of our Federal and State governments to undertake all possible measures to assess accurately the public health significance of the present fallout situation, and to prepare for actions to safeguard the public health if these become necessary."

Federal officials said radioactive fallout on the United States will increase next February, March, April and May when the late winter and spring rains wash to earth the remainder of the fallout from the Soviet nuclear tests but it isn't expected to reach a danger level. President Kennedy said any U.S. nuclear tests in the atmosphere would be designed to hold radioactive fallout to an absolute minimum.

The PHS said that the nation's health authorities are giving careful consideration to the possible situations that might require various corrective actions.

"It is evident that an important element of health protection is continuous surveillance and analysis," the PHS said.

"To achieve this, a number of Federal-State systems for public health surveillance, detailed investigation, and radiation control measure have been developed . . . In cooperation with State and local health departments, the PHS operates a nationwide early warning atmospheric radiation surveillance network currently comprised of 58 stations, and a 60-station milk radiation monitoring system. In addition, the PHS has well-established networks for general air and water pollution monitoring with a total of 343 stations. All of these include radiation monitoring among their capabilities and all are being expanded. For example, daily samples of drinking water are being collected in 12 major cities and analyzed for specific radioactive content on a weekly basis, and plans are ready for more extensive monitoring if necessary. Rounding out the PHS resources is a system of highly specialized regional radiological health laboratories.

"The Food and Drug Administration has expanded its program of monitoring the levels of radioactive contamination in foods. Working through 18 District offices and 39 Resident Inspection Stations, its inspectors are sampling foods from all parts of the Nation; particularly those areas where the Public Health Service's air monitoring network has indicated the highest concentration of atmospheric contamination. Additionally, FDA collects samples from selected lots of food being imported into the United States.

"These samples are being analyzed for total beta activity and selected samples are further tested to determine what specific radioisotopes are present and in what amount.

"In addition there are the extensive special-purpose radiation surveillance and research facilities of the Atomic Energy Commission and the Departments of Defense, Commerce, and Agriculture.

"All Federal programs and resources work in close

(Continued on Page 1261)

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*Gamble, C.J.: Am. Pract. & Digest. Treat. *11*:852 (Oct.) 1960. See also Berberian, D.A., and Slighter, R.G.: J.A.M.A. *168*:2257 (Dec. 27) 1958; Kaufman, S.A.: Obst. and Gynec. *15*:401 (March) 1960; Warner, M.P.: J.Am.M. Women's A. *14*:412 (May) 1959.

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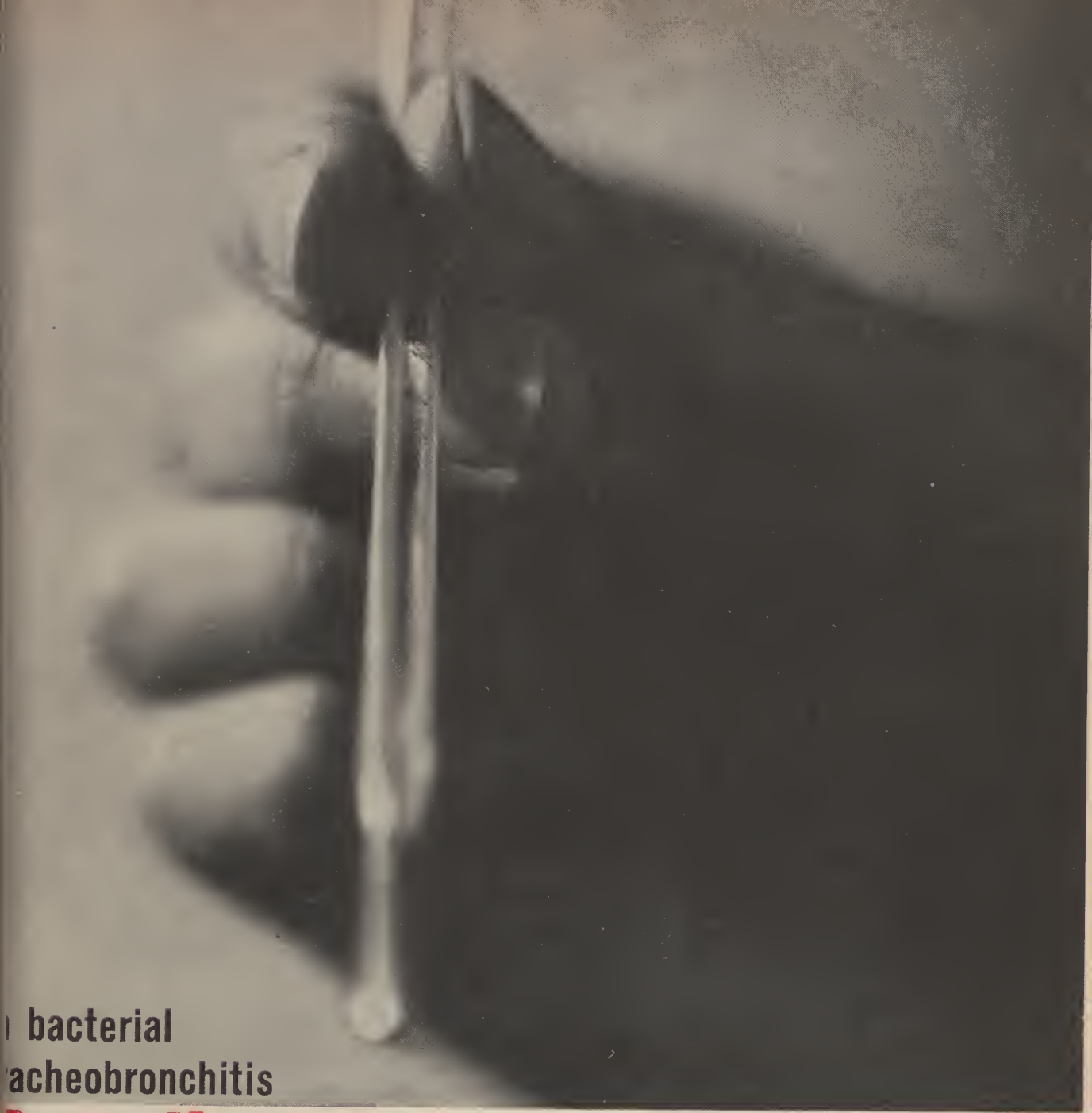


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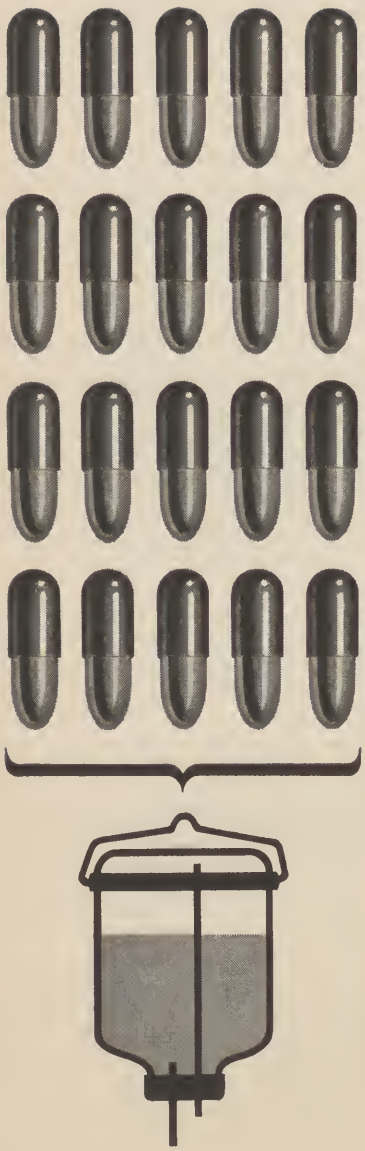
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The JOURNAL of the
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VOL. 59 DECEMBER, 1961 NO. 12

Pulmonary Sarcoidosis

Stuart Graves, Jr., M.D.

Louisville, Ky.

The extreme variability of the extent and severity of sarcoidosis makes the diagnosis and treatment a stimulating clinical exercise.

SARCOIDOSIS is usually a completely benign disease. At times, however, it is capable of producing severe damage or destruction of an organ or organs. The resulting disability, or even death, that occasionally occurs poses a difficult question to the physician. Do I, or do I not treat a particular patient with sarcoidosis? This paper shall present a common type of case of sarcoidosis and will discuss some of the more recent opinions as to etiology, manifestations, and indications for treatment of this disease.

Case Report

History and physical examination: The patient, a 23-year-old white female, was admitted to the hospital on November 2, 1955, because of a superior mediastinal shadow. She was first seen in the office on September 12, 1955, complaining of nervousness. This nervousness consisted of episodes of spontaneous crying and mental depression. The episodes had been occurring about twice a year for the last five years. However, for the two months prior to admission the depression and tearfulness had been rather common. There were no symptoms referable to the respiratory system. The patient was a well developed, healthy appearing, somewhat overweight individual, 61 inches tall and weighing 127 pounds. Blood pressure was 114/84 and pulse was 75. Examination of the eyes, ears, nose and mouth was normal. Breasts revealed some hair about the areolae. The heart, lungs, abdomen, pelvis, and extremities were normal.

Laboratory data: Urinalysis and complete blood count were normal. Blood sugar was 88 mgs.%, VDRL was non-reactive, Bence Jones proteins were not found in the urine, total protein was 9.18 gm.%, and sedimentation rate was 10 mm. in one hour. An electrocardiogram was normal. Bone X-rays of skull, pelvis, spine, ribs, and hands revealed no abnormalities. Bone marrow examination revealed some increase in plasmocytes, but nothing diagnostic of multiple myeloma. A routine chest film taken on 9-12-55, (figure 1) revealed widening of the superior mediastinum and peribronchial infiltration radiating out of the right hilum. A repeat film on 10-28-55 showed an increase in the size of the mass and hospitalization was advised. The admission film dated 11-3-55, (figure 2) shows this rapid increase.



Figure 1.

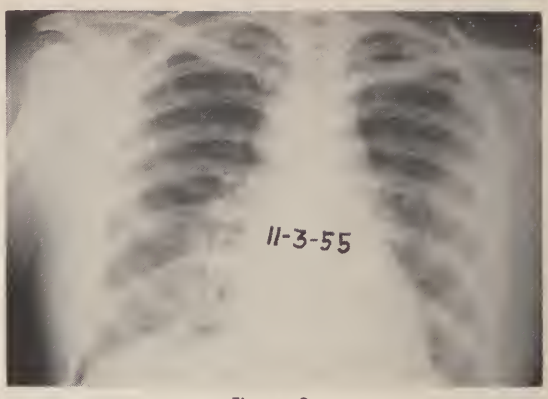


Figure 2.

Course in the hospital: After the above work-up was completed, biopsy of superior mediastinal fat, containing several small nodes, was done through an incision in the base of the neck. The pathological diagnosis was Boeck's sarcoidosis (figure 3).

The patient was started on Prednisone 10 mg. t.i.d. on 11-10-1955. After five days the Prednisone was reduced to 5 mg. q.i.d. and the patient was discharged on November 15, 1955. On November 21, 1955, Prednisone was lowered to 5 mg. t.i.d. A chest film on December 21, 1955, (figure 4), revealed a distinct clearing of the infiltration of the right lung and diminution in the size of the mediastinal mass. X-ray improvement continued and the Prednisone was reduced to 5 mg. b.i.d. on January 20, 1956. A chest film on March 2, 1956 (figure 5), was interpreted as normal. On June 4, 1956, Prednisone was reduced to 5 mg. daily and it was discontinued entirely on September 19, 1956. The patient never had any respiratory symptoms or symptoms contributable to Prednisone. She has remained asymptomatic, except for occasional nervousness and her most recent chest film on October 27, 1960 remains normal.

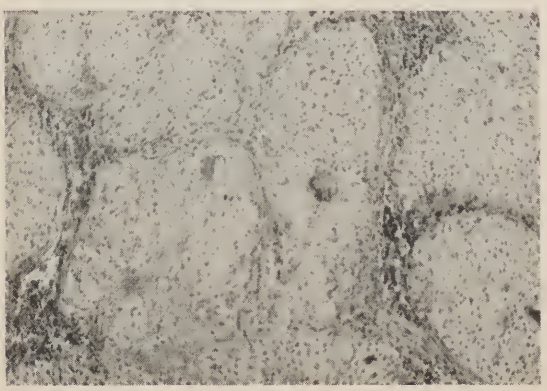


Figure 3.

Discussion

Sarcoidosis is a chronic disseminated disease of unknown etiology. The characteristic lesion is a granuloma made up of pale epithelioid cells. These cells occur in isolated groups or in well defined nodules. The nodules do not undergo necrosis or caseation and surrounding inflammatory changes are absent. Hence, the name "hard nodules." Large multinucleated pale giant cells containing inclusion bodies may be present. The normal evolution of the lesion is to fibrosis. Calcification does not occur.

Etiology

The etiology of this condition is under active discussion. Basically there are two schools, one which believes that sarcoidosis is an atypical form of tuberculosis, and the other which feels that there is a specific etiologic agent as yet undiscovered. Most of the American and Scandinavian writers favor the latter opinion. The group favoring the tubercle bacillus as the specific agent base their belief on the similarity of the histologic picture, the chronic nature of the disease, and the observation that a greater than expected number of patients with

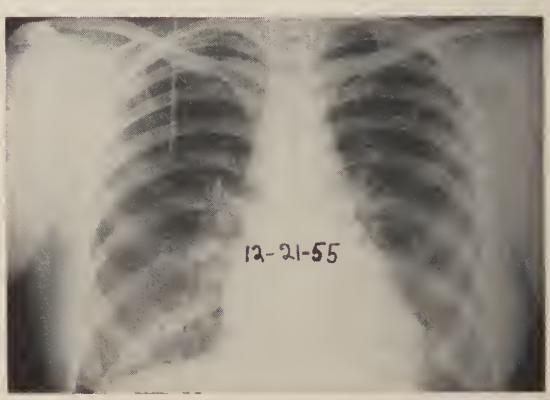


Figure 4.

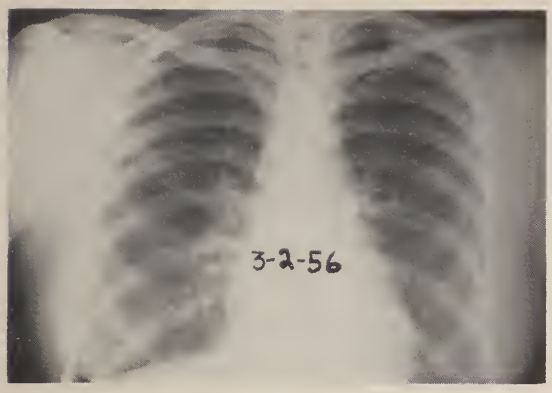


Figure 5.

sarcoidosis die of active bacteriologically proven tuberculosis. They also point out the similarity between sarcoidosis and the rare indolent case of tuberculin negative tuberculosis.

The tuberculin reaction has been investigated at great length and has been used as support by both etiologic schools. All agree that the aqueous tuberculin reaction is negative in most cases, or at least only weakly positive to a large dose of tuberculin. This does not necessarily mean that the patient does not have or never has had a tuberculous infection. A number of patients have been observed to go from tuberculin positive to tuberculin negative with the onset of sarcoidosis and return to a positive reaction when the sarcoidosis regresses. All also agree that patients with Hodgkins' disease and other types of reticulosis usually are tuberculin negative. James[2] showed that if tuberculin negative patients were retested with five T.U. in an oily delaying vehicle, two-thirds of the patients under these conditions would show a positive reaction.

Although patients with sarcoidosis fail to show skin sensitivity to various intradermal antigens, their ability to produce circulating serological antibodies remains unimpaired. This dissociation between cellular and circulating anti-bodies is the basis for an ingenious test described by Quinn and co-workers.[3] Mumps antigen was used because most adults give a positive reaction to both the skin test and complement fixation test. Sarcoidosis is suggested when one finds a negative skin test associated with a positive complement fixation test. The same finding was noted in Hodgkins' disease and other forms of reticulosis with skin anergy.

Additional evidence against the tuberculous etiology is failure to isolate the tubercle bacillus from sarcoid lesions or to produce tuberculosis in laboratory animals. Also it is noted that when tuberculosis does develop in the patient with sarcoidosis the isolated organism has the same cultural characteristics and virulence as usually seen.

More recent investigation of the etiology of sarcoidosis has utilized the epidemiological approach. Chapman,[4] after a world-wide inquiry concluded that, one, the American Indian and Chinese are relatively free from sarcoidosis. Two, the negro race, which has a high incidence of the disease in America seems to be free from the disease in his natural habitat and develops sarcoidosis only when he comes into contact with European modes of life. Three, sarcoidosis seems to be a disease of temperate and subarctic climates and is rare in equatorial areas. Four, the disease is rare before the age of 10 and the highest incidence is from 30-40 years of age. And, five, the sexes are equally affected. Cummings, et al,[5] reviewed 1,194 cases seen in 172 V.A. Hospitals from 1949 to 1954 and suggested that there was a good correlation between the incidence of sarcoidosis and the forest distribution of the United States. Further investigation[6] demonstrated pine pollen to have acid fast staining characteristics similar to the tuberculous bacillus and some of the chemical constituents are also similar. Finally pine pollen is capable of evoking an epithelioid cell granulomata in normal animals. All of this does not prove that pine trees cause sarcoidosis, but it is an interesting approach to the problem and is certainly worthy of continued study.

Morbid Anatomy

All of the organ systems of the body may be involved, with the exception of the adrenal gland.[7] This gland is very rarely if ever the site of sarcoidosis. There are two interesting aspects to this observation. One is the usefulness of corticosteroid in treatment of sarcoidosis. Two, the adrenal gland is a common site of tuberculous infection which would seem to be against the tuberculous etiology of sarcoidosis. Although essentially the entire body may be the site of involvement, the organs vary as to the frequency. Lung, lymph nodes, liver, spleen, heart, kidney, pancreas, and bone marrow are much more commonly diseased than

are brain, meninges, skin, eye, tonsil, antrum, pleura, prostate, testis, epididymis, seminal vesicle, thyroid, parathyroid, pituitary, skeletal muscle, small intestine, and adventitia of great vessels. Stomach involvement has been reported on only three occasions.[8] The decreased frequency of involvement of some of this latter group may be more apparent than real, because they are rarely studied routinely in autopsy material.

Diagnosis

The diagnosis of this disorder remains based on the tissue examination of biopsy obtained material. Formerly only cutaneous and peripheral lymph nodes were used as a source of tissue for histologic study. More recently it has become apparent that many other tissues contain the classical tubercle. Branson and Park[9] reported liver involvement in 76% of biopsy and 66.5% of autopsy cases. The prescalene lymph node biopsy, random muscle biopsy, bronchoscopic, and nasopharyngeal biopsies often give positive information. Nickerson [10] and Kveim[11] independently described an intracutaneous test useful in the diagnosis of sarcoidosis. The test consists of the injection of a saline suspension of ground sarcoid lymph node or spleen. This results in a papule that will persist for several weeks or months. Biopsy and study of this papule reveals a tuberculoid granuloma similar to spontaneously occurring sarcoidosis. The only drawbacks to the test are the time involved and the lack of availability of potent and specific testing suspensions.

Useful, but not diagnostic are several laboratory tests. The tuberculin test has already been discussed as well as the mumps antigen test described by Quinn. Leukopenia below 7500 is found in the majority of cases. Anemia is not the rule; however, occasional hemolytic anemia with splenomegaly has been described.[12] Elevation of the plasma proteins is frequently found (as it was in this case) and accurate electrophoretic studies reveal this elevation to usually be due to an increase in the gamma globulins.[7]

An interesting occasional observation in this disease is that of hypercalcemia. This is not necessarily associated with bone involvement. The hypercalcemia often leads to renal calculi and/or diffuse renal calcinosis with renal insufficiency. The phosphorus is normal, thereby distinguishing the hypercalcemia of sarcoidosis from hyperparathyroidism. Albright and his group[13] discussed this phenomenon at length and feel that the hypercalcemia is due to a disturbed metabolic pattern closely resembling that of Vitamin D over-dosage. They suggested several possible mechanisms: 1. increased skin photosensitivity, 2. decreased inactivation of vitamin D, 3. production of a vitamin D like substance by sarcoid tissue, and 4. altered intestinal flora in sarcoid patients with increased production of vitamin D like substance.

Larson et al,[14] supports the decreased inactivation of vitamin D theory of Albright. They produced hypercalcemia in 12 of 24 patients with sarcoidosis by giving them 30,000 to 140,000 units of vitamin D for 6 to 124 days. The normal patient is rarely poisoned with less than 200,000 units given for months or years.

Elevation of alkaline phosphatase is also occasionally seen. This increase usually cannot be correlated to bone disease, liver involvement, or calcium levels. X-ray examination revealing the classical hilar adenopathy or the punched out lesions of the bones of hands and feet are helpful aids in the diagnosis of this disease.

Clinical Manifestations

The clinical manifestations of the disease are extremely variable depending upon which organ system or systems are involved. Often there are no symptoms whatever, the diagnosis being made as a result of routine X-ray screening or careful eye examination. Of the generalized symptoms, weight loss, fatigue, cough, dyspnea, and chest pain occur in from 25 to 50% of patients and probably represent the common involvement of the lung and liver.[15] The incidence and detailed manifestations resulting from sarcoidosis of the various organ systems is beyond the scope of this paper and one is referred to two complete works on this subject. [7, 15]

Treatment

Treatment of sarcoidosis is extremely difficult to evaluate because of the usual benign nature of the disease and its marked propensity for spontaneous remissions and even complete recovery. Historically a great many agents have been used including ultraviolet light, X-ray,

radium, tubercle bacilli extract, vitamin D, antibiotics, nitrogen mustard, urethane, arsenic, and isoniazid. At the present time it is generally agreed that ACTH and corticosteroid are the only forms of treatment that are useful. Several years ago many authors cautioned physicians regarding the use of this group of drugs for fear that latent tuberculosis would be activated. Others, who subscribed to the tuberculous etiology of sarcoidosis, felt that the disease would be transformed into fulminating tuberculosis. Fortunately this has not proven to be the case.

The literature is full of case reports and series of cases that have been successfully treated with ACTH and steroids.[16-23] It has also been noted that many cases of sarcoidosis improve during pregnancy. [21, 24] It is the feeling of Peters, and Spaeth[21] that this improvement is due to ACTH production of the human placenta.

Although ACTH and corticosteroid treatment almost always results in clinical improvement there have been several well documented reports where this is not the case. Jackson and Hood[25] reported a case of generalized sarcoidosis that developed diabetes insipidus, pituitary myxedema and testicular atrophy while on cortisone therapy. This was presumably due to progressive sarcoid involvement of the pituitary gland. Kelly and McHardy[26] had a case of sarcoidosis, primarily of the liver, that was diagnosed early and treated intensively with ACTH and corticosteroid. In spite of this the patient developed progressive liver cirrhosis and died of liver failure in one year's time. The authors felt that possibly the treatment resulted in an accelerated change from a granulomatous picture to one of diffuse fibrosis and hyalinization. Two cases are reported[27] that developed vascular lesions while on cortisone therapy. Because vascular lesions are very rare in sarcoidosis, cortisone was probably responsible.

In spite of these few disturbing reports ACTH and corticosteroid offer the patient the only hope if he has progressive disease of a vital organ. Simple skin sarcoidosis and asymptomatic hilar adenopathy probably should not be treated at all, observation being quite sufficient. Treatment should be used promptly in the following conditions: 1. acute miliary dissemination of the lung with alveolar capillary block syndrome, 2. progressive lung involvement. Here the purpose is to prevent pulmonary fibrosis. 3. late fibrotic scarring with dyspnea. Treatment in these cases does not reverse the scarring, but is symptomatically helpful. 4. ocular, any central nervous system, or direct cardiac involvement. 5. splenic involvement with hematologic disorders. Splenomegaly in itself, unless tremendous, is not sufficient indication. 6. disfiguring cutaneous lesions. 7. renal damage with or without hypercalcemia. 8. fever and marked weight loss. These symptoms are often due to hepatic infiltration. 9. salivary gland involvement. If one embarks on ACTH and/or corticosteroid treatment he should be prepared to continue it for several months as a minimum. In some cases permanent maintainance therapy has been necessary to prevent relapse.

Summary

A case of histologically proven pulmonary sarcoidosis is reported. The patient responded promptly and objectively to a moderate dosage of prednisone.

The recent literature on sarcoidosis is reviewed and discussed from the standpoint of etiology, morbid anatomy, clinical manifestations and treatment.

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(Continued on Page 1261)

Indications For Left Heart Catheterization*

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Stenosis and regurgitation of the mitral and aortic valves must be accurately assessed before surgery. Coexisting lesions must be evaluated. The indications and methods for left heart catheterization are discussed.

NEW techniques for physiologic evaluation of the cardiovascular system have been developed in the past decade to keep pace with rapid advances in cardiovascular surgery. A brief review of the methods used for left heart catheterization and the indications for their use is presented here.

Mitral Stenosis

Pure stenosis of the mitral valve is easily relieved by simple finger-fracture of the fused mitral commissures. The indication for mitral valve surgery is the presence of symptoms and signs of mitral valve obstruction (exertional dyspnea, pulmonary congestion, hemoptysis, persistent congestive failure of the right ventricle or the appearance of a systemic embolus). Unfortunately, these findings are not limited to mitral valve obstruction and are commonly found in many types of heart disease. If mitral stenosis is the sole cardiac lesion there is usually no difficulty in clinical assessment of the cardiac status but when mitral stenosis coexists with other valvular lesions or with another form of heart disease, the physicians skill may be severely taxed.

Particular difficulty is encountered when mitral regurgitation coexists with mitral stenosis. In this instance it is of utmost importance to determine which lesion predominates, for surgical finger-fracture will not benefit predominant regurgitation and, indeed, may make it worse. New surgical methods are being developed for the correction of mitral regurgitation and these differ considerably from the simple finger-fracture method for mitral stenosis. It is thus necessary that the physician be aware not only of the indications for surgical intervention but also of which type of surgical procedure is required for the valvular lesions present.

With the development of hypertension in the pulmonary vascular bed and right heart failure, regurgitation at the tricuspid valve may ensue. When this occurs, the right ventricle will enlarge and push the left ventricle posteriorly and the right ventricle will then comprise the apex of the heart. An apical holosystolic murmur due to the tricuspid regurgitation will then be present and this may be indistinguishable from the murmur of mitral regurgitation. The differential may be easy if the classic signs of tricuspid regurgitation are found (systolic pulsation of the liver, a large systolic "v" or "regurgitation" wave in the jugular venous pulse and intensification of the murmur with inspiration). In the absence of these signs, mitral and tricuspid regurgitation may not be readily differentiated.

Another problem is encountered in subjects with aortic regurgitation. In these individuals, it is difficult to decide if a rumbling diastolic murmur heard at the apex of the heart represents the insignificant functional murmur of

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Austin Flint or the murmur of significant mitral stenosis.

Occasionally mitral stenosis may not be the only lesion and may be compounded with another cardiac disorder such as rheumatic myocarditis or arteriosclerotic heart disease. It is very important to know if the stenosis or the myocardium is at fault in these instances since it is extremely hazardous to submit a subject with predominant myocarditis or arteriosclerotic heart disease to an unnecessary thoracotomy.

Aortic Stenosis

Aortic stenosis may be surgically alleviated by blind transventricular dilatation of the valve or by commissurotomy during cardiopulmonary bypass with the pump-oxygenator. Both of these are hazardous major procedures and it is necessary that aortic valve hemodynamics be accurately evaluated preoperatively. Clinical assessment of disease of the aortic valve is not only difficult but is insufficient and laboratory measurements of valve functions are always necessary.

It is well known that the classic findings of aortic stenosis may be present clinically with only minimal laboratory evidence of valvular obstruction. It is hard to reconcile a loud aortic systolic murmur and thrill and x-ray evidence of left ventricular hypertrophy and aortic valvular calcification with only mild obstruction to the flow of blood. Nevertheless, this combination exists, and laboratory examination will not reveal a pressure gradient across the aortic valve.

Aortic stenosis may be complicated by aortic regurgitation and the predominant lesion must be known. Obviously, transventricular dilatation of the valve will not benefit aortic regurgitation and is therefore contraindicated when regurgitation predominates. Replacement of an incompetent aortic valve with a plastic prosthesis is currently in the developmental stage and at present, patients with predominant aortic regurgitation are denied surgery.

Of course, aortic stenosis may also be found in the presence of myocarditis or arteriosclerotic heart disease and laboratory measurement of the significance of the aortic stenosis is required before surgery can be considered.

Congenital Heart Disease

Rarely, a patient with an atrial septal defect may also have mitral stenosis (Lutembacher's Syndrome). To make this diagnosis, it is necessary to know if there is a pressure gradient across the mitral valve in diastole and left atrial and left ventricular pressures must be measured. An indicator dilution curve or angiocardiogram with left ventricular injection of the dye will demonstrate mitral regurgitation in cases of septum primum atrial defects and help to differentiate them from septum secundum defects. Congenital septal defects may also be compounded by aortic stenosis and the severity of the stenosis must be known. Access to the left heart is also sometimes necessary to demonstrate a small left to right shunt by indicator dilution curves or angiocardiograms.

Left Heart Catheterization

Because of these clinical difficulties, many methods have been developed to gain access to the left heart. Measurement of the pressures in the left atrium and the left ventricle will reveal a diastolic pressure gradient across the mitral valve if mitral stenosis exists and usually the higher the pressure gradient, the more severe the stenosis. There is no diastolic pressure gradient across a normal mitral valve. The pressure is a function of blood flow and the higher the flow the higher the pressure gradient. For this reason cardiac output is determined at the time of the pressure measurements. The dye dilution method is used for the measurement of cardiac output and, in addition, gives an indication of the severity of any valvular regurgitation which may be present.[1]

The simultaneous measurement of the pressures in the left ventricle and in a systemic artery or the aorta will reveal a systolic pressure gradient if aortic stenosis is present.

The left atrium may be entered by a number of methods:

1) *Dorsal percutaneous*[2] — Under local anesthesia a needle is passed through the back, beside the thoracic vertebrae and into the left atrium.
2) *Substernal*[3]—Under local anesthesia a long needle is passed from the suprasternal notch, under the sternum, through the mediastinum and into the left atrium. In its course the needle

pierces the aorta and the pulmonary artery.

3) *Transbronchial*[4, 5, 6] — A small bronchoscope is inserted into the trachea and a long needle is used to perforate the left main stem bronchus, just lateral to the carina. The adjacent left atrium is then punctured.

4) *Transseptal*[7]—A large catheter is placed in the right atrium from a saphenous vein. A long needle with a curved tip is passed through the catheter and as it leaves the distal end it pierces the interatrial septum and enters the left atrium.

In all of these methods except the substernal approach, a small catheter may be passed through the puncturing needle and manipulated across the mitral valve. Left ventricular pressure may then be recorded and pressure may also be recorded as the catheter is withdrawn from the left ventricle to the left atrium. In this manner, mitral valve hemodynamics may be measured.

If the left ventricle cannot be entered with the exploring catheter, it may be punctured at the apex with a needle[8] and its pressure recorded at the same time the left atrial pressure is recorded. This technique is also employed to measure left ventricular pressure in the presence of aortic stenosis.

At present, we employ the transseptal technique of left atrial puncture and the apical ventricular puncture. Both of these are very safe procedures and they yield maximum information. As soon as the pressures are measured an indicator dilution curve is obtained to measure cardiac output.

Left heart catheterization has a small risk associated with it. Cardiac tamponade, pneumothorax, hemothorax, mediastinal hematoma, and, rarely, death have been reported as complications of the procedure. There are no reported complications of transseptal puncture of the left atrium[9, 10] and only one death has been documented following apical puncture of the left ventricle. There have been no complications with either of these two methods in our experience.

Summary

By left heart catheterization, the severity of mitral or aortic stenosis may be measured, the presence and severity of any valvular regurgitation may be estimated and the presence of heart failure or shunts may be revealed. With these laboratory measurements the perplexed physician may be helped considerably in his clinical assessment and therapeutic decision. The indications for these procedures have been discussed.

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Hydroxyzine* In Labor And Delivery

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Hydroxyzine, useful in the first stage of labor, is effective preanesthetic medication, permitting reductions in meperidine and scopalamine, without causing untoward effects in mother or child.

SEARCH has continued for better pain-relieving agents to help women through the first stage of labor and to serve as premedication to anesthesia for delivery. The promise of certain earlier tranquilizing agents, with their potentiating properties for narcotics, remained unfulfilled when jaundice and hypotension were reported from their use.

Hydroxyzine hydrochloride is an effective ataractic substance which permits reduction in narcotics when these agents are used together; the drug is not known to cause jaundice or hypotensive effects. This paper will report a controlled clinical evaluation of hydroxyzine hydrochloride as an ataractic agent during the first stage of labor and as premedication to anesthesia for delivery. World medical literature contains additional papers on hydroxyzine in this general field of application.[1-8]

Plans and Procedures

Two groups of patients were established. Both groups were seen in the obstetrical service of a metropolitan hospital. Group I, a control series, consisted of 50 private patients. The women were from 18 to 39 years old. Eighteen patients were gravida one; 12, gravida two; 5, gravida three; 7, gravida four; and 8, grand multipara, the maximal number being 9 pregnancies.

The control group received routine medication consisting of a barbiturate, meperidine and scopolamine. The barbiturate was administered shortly after admission of patients to the hospital and was usually three grains of secobarbital; 100 mg. of meperidine, and scopolamine, grains 1/150, were given either intravenously or intramuscularly as indicated by the condition of the patient. When labor extended over 4 hours, the patient was given another dose of meperidine 100 mg. with 1/300 grains scopolamine; the second dose of meperidine was divided, 50 mg. being given intramuscularly and 50 mg. intravenously.

Anesthesia for all control patients was low spinal (usually saddle block) given at approximately four fingers dilation. About 30 per cent of the women had been admitted for elective induction of labor. One patient was severely toxic on admission; her blood pressure was 180/100. In addition to the barbiturate-meperidine-scopolamine routine, she also received magnesium sulphate intramuscularly on admission and cryptenamine intravenously for lowering the blood pressure.

Group II (the test series) comprised 122 clinic patients. Ages here ranged from 15 to 43 years old. Twenty-nine patients were gravida one; 23, gravida two; 20, gravida three; 14, gravida four; 17, gravida five; 7, gravida six; 9, gravida seven; 1, gravida eight; 1, gravida ten; and 1, gravida eighteen.

Patients in this group were given hydroxyzine, 50 mg. intramuscularly, on admission; meperidine 50 mg. and scopolamine grains 1/300 (half the amounts given to the control patients) were administered intravenously as required. With the exception of 2 toxic patients

*ATARAX. Product of J. B. Roerig and Company, Div., Chas. Pfizer & Co., Inc.

who received general anesthesia, low spinal anesthesia was used in this series also.**

Results

In Group I, the control series, the average length of the first stage of labor was approximately 4 hours and ten minutes; the shortest labor period was thirty minutes and the longest, 12 hours. With the conventional premedication-routine used, analgesia for all women in the control group was considered adequate.

There were no remarkable blood pressure changes that could be associated with either the analgesic drugs used or the type of anesthesia given for delivery.

With the exception of one stillborn infant, a macerated fetus, all of the babies in the control group breathed spontaneously within one minute after delivery and required only bulb resuscitation. Since three of the infants in this group weighed less than 5 pounds, they were placed in oxygen in the premature nursery. Birth weights of babies in the control series ranged from 4 pounds 1 ounce to 9 pounds 6½ ounces. No attempts were made to follow the course of infants after they left the delivery room.

In Group II (the hydroxyzine series), the length of the first stage of labor varied from 30 minutes to 16 hours. The majority of the patients delivered within 6 hours of admission to hospital. Of the 122 women, 99 required only one injection of hydroxyzine hydrochloride, and 23 required 2 or more injections. Follow-up injections were not needed until at least 4 hours had elapsed.

Seventy-nine patients required only 50 mg. meperidine at the first painful contraction. Two injections of meperidine were required by 42 women, and more than 2 by only one patient; meperidine was given during this study whenever the patient became uncomfortable. With scopolamine, 92 patients received only 1 injection of grains 1/300; 28 were given two injections, and two patients, 3 injections. In only 3 women was this pre-delivery medication unsatisfactory. These patients all had very violent, short labor, delivering less than 1 hour after admission to the hospital.

Labor was induced in 3 women, for prematurely ruptured membranes or toxicity. Five deliveries were by breech extraction. One of a pair of twins was stillborn while the other survived only 10 minutes; their weights were less than 4 pounds each. Nine other infants were premature births; of these, 3 weighed less than 3 pounds and did not survive more than 10 minutes. The larger premature babies survived and did well. Most of the normal babies weighed between 7 and 8 pounds at birth, and the largest baby in this test-series was 10 pounds 4 ounces.

In the group of 122 women who received hydroxyzine hydrochloride as premedication, 105 of their infants breathed spontaneously upon delivery, while 10 required from two to three minutes before a lusty cry was elicited. The remaining seven infants were either stillborn or died almost immediately neo-natally.

There was no hypotension in any patients as a result of administration of hydroxyzine hydrochloride. Of the 122 clinic patients, 11 had blood pressures of 140/90 or higher on admission. Of this number, only 4 had a blood pressure of 140/90 or higher after administration of the anesthesia. There were only two instances of blood pressure dropping more than 10 points systolic after the administration of the anesthesia; the blood pressure was 90/50 and 92/60 in these patients.

Observations and Comments

Apart from these objective findings, physicians and hospital personnel rated the degree of relaxation and cooperativeness of patients. Nurses in the labor room judged the hydroxyzine-patients to be more cooperative and relaxed than those not given the compound.

It was gratifying to all concerned that, with an appreciably reduced amount of meperidine and scopolamine in the majority of patients in the hydroxyzine series, a satisfactory plane of analgesia could be maintained. With the exception of the two patients given general anesthesia, all of these women were awake at time of delivery. There were no postoperative anesthetic complications. The two women given general anesthesia had been admitted in extremely toxic condition; blood pressure had been above 190 systolic and above 110 diastolic. However, hydroxyzine helped considerably in the management of these extremely ill

**Since completing the study reported here, the author has undertaken to use 100 mg. hydroxyzine rather than 50 mg. He now feels 100 mg. is the optimum dose.*

women without incident. The only sedation used was hydroxyzine 50 mg., repeated at 4 hour intervals, and meperidine 50 mg., scopolamine grains 1/300 as needed.

One patient given hydroxyzine vomited during her first stage of labor. Since patients were delivered under low saddle block anesthesia, the one episode of vomiting did not pose a problem.

Conclusion

Hydroxyzine hydrochloride is an excellent drug to be given routinely along with reduced amounts of conventional medication to aid women during the first stage of labor and as premedication to anesthesia. With hydroxyzine, patients generally display an improved capacity for cooperation during their labor and delivery. Adequate analgesia, without loss of consciousness or overuse of barbiturates, is more readily attainable by inclusion of the ataractic in the pre-delivery regimen.

Administration of hydroxyzine permitted reduction by one-half of the amount of meperidine required in 65% of the patients, and by one-half the amount of scopolamine required in 75% of the patients. In this series, hydroxyzine caused no hypotensive or other untoward effect upon the mother, nor was there any delayed respiration in the babies, attributable to hydroxyzine. Two toxic patients were well managed with the help of hydroxyzine and other drugs. The one episode of vomiting which occurred in the entire hydroxyzine series did not interfere with low saddle block anesthesia. Post-anesthetic difficulties were not encountered.

Every physician must be prepared to continue to evaluate drugs which promise to safely aid his patients in childbirth. Hydroxyzine is strongly commended to the attention of practitioners seeking to improve their routine management of labor and delivery.

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Atypical Acid-Fast Organism Infection for the Skin

An atypical acid-fast organism belonging to the scotochromogen group of Runyon's classification was cultured from a granulomatous skin lesion of the elbow. This organism was isolated on 2 separate occasions and careful cultural techniques failed to grow any other organism. Specific granulomatous skin infections due to *Mycobacterium balnei* and *Mycobacterium ulcerans* have been previously established in the literature. The problems and the present status of cutaneous infections due to atypical acid-fast organisms were reviewed. The possibility is raised that some granulomatous lesions ordinarily attributed to the tubercle bacillus may actually be caused by other mycobacteria. Accurate bacteriological indentification of the etiologic agent is important because a tuberculoid granuloma of the skin even in the presence of acid-fast bacilli in tissues cannot be assumed to be due to the tubercle bacillus.

—J. M. Knox et al.; Arch Derm—Vol. 84:386 (Sept.) 1961

Ammoniacal Dermatitis

Guy C. Cunningham, M. D., F.A.A.P.

Ashland, Ky.

Ammoniacal dermatitis is still one of the more common skin irritations seen in office pediatric practice. Its prevention and treatment are important to the physician, the parent and the infant.

A PERPLEXING skin irritation, quite often recurrent, is the commonly seen excoriated skin about the buttocks and diaper area of infants. It is referred to by the parents as "raw bottom," "chafing," "diaper rash," or "napkin irritation" and is known to the physician as ammoniacal dermatitis. The fact that the exact etiology of this common skin irritation has been known for years[1] has not reduced its occurrence. This may signify that prevention is impossible, or it might indicate the unusual skin sensitivity of many infants, or it may be lack of adequate instruction by the physician to the new mother on skin hygiene. It is not the purpose of this paper to elucidate further on why it continues to be one of the more common forms of skin irritations seen in pediatric office practice today. It will suffice to state that it is still very worrisome to physicians and parents alike.

Etiology and Diagnosis

I am sure we will continue to be asked, "Doctor, what can I do to keep my baby from getting a raw bottom and stop his diapers from smelling like ammonia?." Not many mothers are prepared to absorb the chemical equation causing this. $CO(NH_2) + 2H_2O = (NH_2)_2CO_3 = 2NH_3 + H_2O + CO_2$. This, physicians know, shows the reaction by which ammonia is formed from urea. Neither can mothers completely understand the bacteriology of the process whereby a saprophytic gram-positive bacillus originating in the intestine infests the skin about the buttocks of their infant.[1] However, the end results of the chemical equation and bacteriological process are recognizable on the skin of the infants as ammoniacal dermatitis. It is characterized by erythema of the buttocks, papulovesicular lesions, and by bleeding and ulcerated sores if allowed to go on without treatment. While the presence of the above described skin pathology is usually self-limiting and may eventually heal with good hygiene measures, it does not detract from two very practical points, i.e., that ammoniacal dermatitis is a real source of pain to the infant and mental anxiety to the parent.

Many methods of treating the infant's skin, and the diaper have been evolved and used over the past years with a greater or lesser degree of success.[2, 4, 6-11] The great number of preparations might indicate they are all usable or that the only treatment necessary is careful cleaning of the diaper area and frequent diaper changes. In many cases the latter is true, yet a great number of recurrent or persistent cases continue to be bothersome.

Method of Study

Diaparene® ointment, which was discussed fully in the literature several years ago, seemed to give unusually good results in the office treatment of ammoniacal dermatitis when used by the present author.[2-11] In an effort to check the efficiency of the ointment further, it was decided to conduct an office experiment under something less than ideal scientific conditions.

The parents of approximately one hundred office patients were given hygiene and guidance instructions in the care of their infants' am-

moniacal dermatitis plus the use of the ointment. Another group of infants with ammoniacal dermatitis were given identical instructions, but no ointment prescribed to act as a "control" group. The parents of both groups were encouraged to keep the diaper area clean with a mild soap and water rinse and to thoroughly dry the skin before a new diaper was applied. They were instructed on proper diaper washing and rinsing.

Observations were carried out on both groups at three, six and ten days. If the infant was not returned to the office a telephone call to the mother soon ascertained in which group in Table I her infant belonged. Approximately twenty per cent of the tabulation of cases was carried out by telephone. The home environment of eighty per cent of these infants represented middle or slightly above average income levels.

As near as could be determined by questioning the mothers, nearly thirty per cent of the cases treated by hygiene alone received some form of therapy. This consisted usually of baby oil, baby lotion, or powder, but some mothers admitted using heat, corn starch, vaseline or zinc oxide ointment. The parents of ten cases who began treatment in the "control" group became unduly apprehensive before the ten-day period was over and received more intensified therapy and thus were discarded in favor of ten additional cases.

Results

TABLE I

		OBSERVATIONS	
Condition of Skin	Days	Control Group	Ointment Group
Unimproved or Slightly Improved	3	43	3
	6	37	0
	10	31	0
Improved or Markedly Improved	3	57	86
	6	61	32
	10	61	11
Healed	3	0	11
	6	2	68
	10	8	89

As a result of finding this ointment to be of value in the treatment of ammoniacal dermatitis, the author decided to investigate its use as a prophylaxis in newborn infants. Accordingly, the ointment was prescribed for 200 infants before they left the newborn nursery. The mothers of these infants were urged to use the ointment on the diaper area twice a day and after each diaper change which contained stool. In Table II the results are tabulated on 120 cases that returned for their four-weeks checkup whose mothers had followed the outlined directions. The mothers were questioned concerning the incidence and frequency of skin irritation to the diaper area and about the presence of perianal dermatitis in addition. Similar questions were asked and tabulated on 120 infants whose mothers used only routine hygiene measures in everyday skin and diaper care. This latter group was used as the "control" group. As might be expected, many of the mothers in the "control" group used only normal home preparations since no specific preparation had been outlined to them. Generally this consisted of oil, lotion, powder, or vaseline. Most of these babies were from homes in the moderate income levels and it could be assumed they gave their infants reasonable hygiene to the diaper area.

TABLE II

	Control	Ointment Group
Little or no trouble with diaper area irritation	76 (63%)	108 (90%)
Only perianal irritation	11 (9%)	7 (6%)
Moderate difficulty with diaper area irritation	25 (21%)	3 (2.5%)
Considerable reoccurring diaper area irritation	8 (7%)	2 (1.5%)
TOTALS	120 (100%)	120 (100%)

It therefore appears that this ointment is an efficient prophylaxis for ammoniacal dermatitis. It has significant, though lesser, value in prevention of perianal irritation. The two cases which showed considerable reoccurring diaper area irritation despite using the ointment were not true cases of ammoniacal dermatitis. On further diagnostic workup, they proved to be monilia infections of the diaper area, and cleared on proper therapy.

Summary

Ammoniacal dermatitis is still one of the more common skin irritations seen in office Pediatric practice. Its effective prevention and treatment are important to the physician, the parent, and to the well-being of the infants under their care. In the author's experience

Diaparene ointment has proved worthwhile in meeting both of these needs. A total of 100 patients in each of the control and ointment groups were studied for treatment of ammoniacal dermatitis (Table I) and 120 patients in each of the control and ointment groups were studied for prophylaxis of perianal dermatitis (Table II). Treatment of existing ammoniacal dermatitis with Diaparene ointment produced good to excellent results in all cases in 3 to 10 days. Maximum improvement with the controls (10 days) was 69%. Prophylaxis (Table II) with the ointment gave 90% protection (control 63%) with mild perianal irritation in an additional 6% (control 9%). No adverse side effects were noted in any infant receiving this form of therapy regardless of how often it was applied. Effective hygiene measures alone are not nearly as efficient in the prophylaxis or treatment of ammoniacal dermatitis. Diaparene ointment may be safely recommended for prophylactic or therapeutic use on the infant's skin and is particularly useful on the diaper area.

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Childhood Urosepsis

Robert Lich, Jr., M.D.*, Lonnie W. Howerton, M.D.** and Lawrence A. Davis, M.D.***

Louisville, Kentucky

The importance of urodysfunction is described. A method of diagnosis is given along with corrective operative procedures.

THE inevitable relationship of urinary tract dysfunction and infection is an unequivocal fact. Furthermore, it is universally recognized that diagnosis during the incipiency of urine transport dysfunction is the key to optimum functional restoration of urinary tract normalcy and the interruption of progressively destructive urosepsis. We will present herein a diagnostic method (voiding vesicourethrography) which permits consistently accurate diagnosis of incipient urinary tract dysfunction and clinically established corrective procedures.

Previous urologic diagnostic procedures (cystoscopy, cystography, etc.) possess the limitation of visualization of morphology alone. Morphological abnormalities must be always the result of malfunction; i.e., the demonstration of a cancerous mass is the visible result of cellular abnormality or an interrupted motor nerve produces immediate muscular dysfunction whereas muscular atrophy is the visible latent structural change. The magnitude of morphologic urinary tract abnormalities is the product of time and the degree of dysfunction; i.e., mild obstruction may be quietly and slowly destructive whereas a marked obstruction can induce similar havoc in a short time. It would seem, therefore, that a method of early diagnosis of disturbed urinary tract must visualize dysfunction primarily and morphology secondarily if we are to achieve the ultimate pinnacle of surgery; namely, functional restoration rather than sublimation.

Advantages of Method

Our method of voiding vesicourethrography by virtue of the x-ray image intensifier affords the attributes of simplicity, accuracy, minimal radiation, consistently reproducible studies and continuous or intermittent monitoring of the entire urinary tract both during vesical filling and voiding. Any abnormality of the urinary tract may be permanently recorded by making a spot film of the particular event; i.e., bladder or urethral diverticulum, vesical neck contracture, ureterovesical reflux, etc. The necessity of spot films must be appreciated since many significant abnormalities are only of momentary duration and are missed completely by current techniques of cystography.

Cinematoradiography (cinefluorography) is impractical for these problems because of greatly increased radiation, less detailed radiographic images, and above all, impracticality of film comparison. Also, urine transport is a relatively slow process so that the present day cinematoradiographic equipment which is adapted to the rapidity of the cardiovascular system is not ideal for urologic problems.

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†*Read before the Norton Memorial Infirmary Third Annual Postgraduate Medical Seminar, December 15, 1960, Louisville, Kentucky.*

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***Instructor in Urology and Chief of Pediatric Urology, Children's Hospital; Department of Surgery.*
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‡*Supplied through the courtesy of Winthrop Laboratories, New York.*

Technique

The technique of voiding vesicourethrography is simple. The bladder is filled to maximum capacity with 15 per cent Hypaque‡ which is prepared with powdered Hypaque and autoclaved. After the bladder is filled the patient is instructed to void, or, in infants, micturition is initiated by suprapubic pressure. During the act of voiding the urethrovesical area is observed through the x-ray image intensifier and any abnormality recorded by spot films, preferably with a rapid film changer. In addition, the urethra and upper urinary tract are scanned and abnormalities recorded.

We have demonstrated characteristic radiographic findings of obstructed bladder neck which elude cystoscopic confirmation. Proof of its existence, however, is substantiated by surgical correction of the obstructed vesical neck, with resultant complete relief of symptomatology and the previously unconquerable recurrent or persistent pyuria.

The normal vesical neck is visualized radiographically as a smooth funnel-like transition from the bladder to the urethra (Figure 1). However, in vesical neck obstructions there appears a distinct dilatation of the immediate proximal urethra with a marked indentation at the vesical neck, affording the appearance of an 'acorn' (Figure 2). The degree of urethral dilatation is directly related to the amount of vesical neck contracture and is associated with a comparable amount of trabeculation of the bladder which is seen as scalloped edges on the associated cystogram.

The urethra and bladder are observed at intervals during the entire voiding phase and the patient is rotated to demonstrate the presence of urethral and vesical diverticula which are most apparent during this technique and are completely invisible cystoscopically. These pockets of seemingly minute pools of residual urine, as visualized cystoscopically and surgically, are often sizable when distended during voiding. Here again, their pathologic significance is attested by the "miraculous" and permanent cure of urosepsis by their excision.

Ureterovesical Reflux

The most startling facet of diagnostic uropathology that has escaped all of our universally practiced diagnostic modalities (cystoscopy, cystography, excretory and retrograde urography) is the functional disturbance of the ureterovesical junction with secondary changes in



Figure 1. Normal vesical neck



Figure 2. Typical obstructed vesical neck (marked)



Figure 3. (A) An apparently atrophic pyelonephritic kidney upon retrograde study which reveals (B) a marked hydronephrosis as shown by ureteral reflux at the time of voiding vesicourethrography

the upper urinary tract. Ureterovesical reflux may be marked and appear as the bladder is being filled with opaque medium or in its initial phase appear but momentarily as the bladder is being emptied during either maximal or minimal vesical systole. The degree of dilatation of the upper urinary tract is often amazing when other studies (cystoscopy and urography) demonstrate relative normalcy (Figure 3). Furthermore, ureterovesical incompetence, contrary to most present day concepts, is not necessarily the result of vesical neck obstruction. Ureterovesical reflux is more often unassociated with bladder neck obstruction.

A detailed discussion of corrective procedures is beyond the scope of this presentation. They are of necessity surgical measures and we will briefly mention the two most common considerations; namely, bladder neck obstruction and ureterovesical reflux.

The surgical correction of the congenitally narrowed bladder neck is accomplished by interposing a tag of normal bladder muscle between the cut edges of the narrowed vesical neck anteriorly and completely incising the

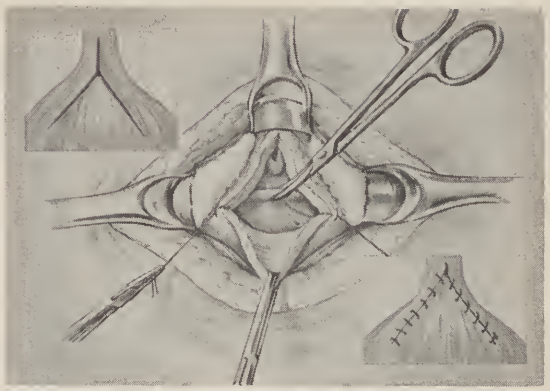


Figure 4. A method of surgical correction of an obstructed vesical neck.

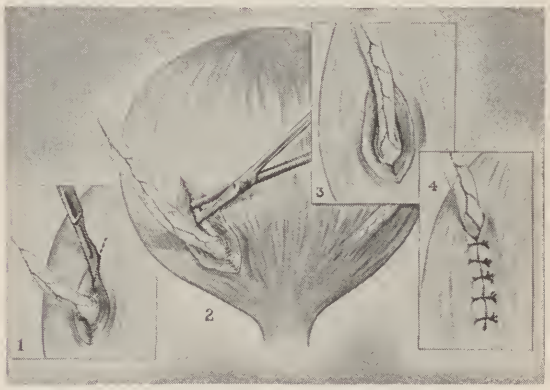


Figure 5. The method of re-embedding the ureter in the detrusor muscle to interrupt ureteral reflux.

vesical neck contracture posteriorly (Figure 4).

The interruption of ureterovesical reflux has been, in our hands, accomplished most effectively both technically and clinically by re-embedding the ureterovesical area of the ureter in the bladder muscle to restore the normal obliquity of the intramural ureter (Figure 5). This method, as opposed to re-implantation of the ureter, provides the advantages of surgical simplicity and an unexplainable but striking reduction in postoperative morbidity.

Summary

A method of urodiagnosis is presented which has afforded the means of determining uropathology heretofore unrecognized in its incipiency.

Corrective surgical measures are illustrated which have successfully terminated symptomatology and urosepsis previously refractory chemotherapeutic or biotherapeutic measures.

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CASE DISCUSSIONS
From The
University of Louisville Hospitals

Louisville General Hospital

Ankylosis Of The Jaw With Oral Bleeding

Robert G. Cooper, M.D.*

V.P. #48909, 58 year old white male admitted to L.G.H. on 3-6-61.

CC: 1. Bleeding from the mouth.
2. Inability to open the mouth.

PI: This patient had an acute dental infection at 8 years of age associated with extraoral drainage which lasted 2 years. Since then he has had progressive difficulty in opening his mouth. At present he eats only soft foods and liquids. For the past several weeks he has had a bloody discharge from his mouth.

PH: Not remarkable except for P.I.

PE: Well developed, well nourished white male who has ankylosis of his right temporomandibular joint and who can open his mouth only slightly. He has multiple carious teeth but an adequate oral examination could not be done because of the ankylosis. Physical examination is otherwise not remarkable except for an atrophic right testicle.

Operation

One assistant was designated to watch the face during the procedure for any twitchings of the facial musculature indicative of facial nerve stimulation. None was seen.

An incision was made beginning at the hair line extending downward through the superior root of the ear, through the margin of the tragus, down the lower root of the ear lobe, posteriorly to the tip of the mastoid, then down the margin of the mandible. The anterior flap was dissected carefully. The facial nerve was not encountered, although it was necessary to carry the dissection through the body of the parotid gland. The periosteum was stripped from the temporomandibular bones. The condyle of the mandible was fused to the zygomatic process of the temporal bone, and the coronoid process was fused to the maxilla. Using the Stryker bone saw, the condylar-zygomatic

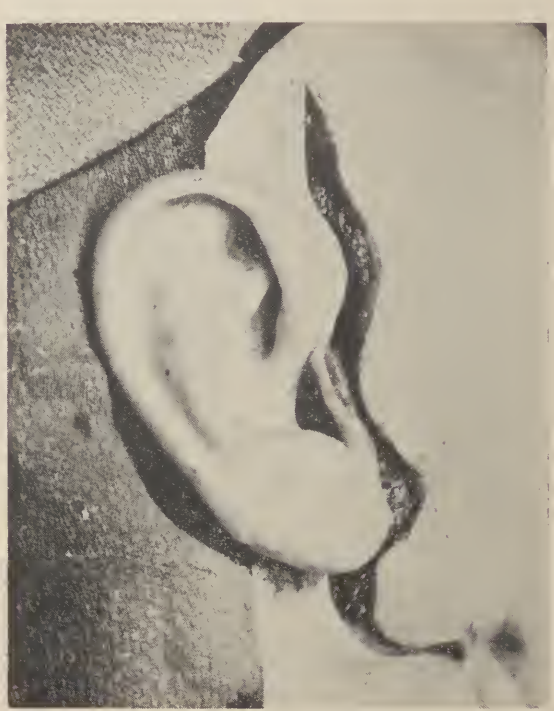


Fig. 1 Illustrates the incision employed to obtain adequate exposure of the condylar area. It follows normal skin creases and lies within the tragus of the ear, giving an excellent cosmetic result.

*From the Department of Surgery, University of Louisville School of Medicine.



Fig. 2 Reveals complete bony fusion with no semblance of a temporomandibular joint or sigmoid notch of the mandible.



Fig. 3 Postoperative appearance following resection of a block of the vertical ramus. The oral cavity is visualized through the wound.

fusion was separated. The coronoid-mandibular-maxillary fusion was chiseled and rongueured. The right masseter muscle was divided. Dental blocks were introduced into the oral cavity to keep the mouth open. The wound was irrigated with saline and closed in layers using 3-0 plain catgut sutures. A cigarette drain was introduced near the angle of the maxilla and mandible and brought out through the anterior part of the incision. The skin was closed with 6-0 nylon sutures and a pressure dressing was applied.

Progress

Postoperatively, the patient did well except for considerable swelling, over his face and jaw, and a partial facial nerve paralysis. He could not close his right eye, so a tarsorrhaphy was done under local anesthesia on 3-23-61.

On 3-26-61, he developed a wound infection below the lobe of the right ear which responded to drainage, soaks and antibiotics.

He was discharged on 4-14-61. The bleeding from his mouth was found to be due to poor oral hygiene, multiple carious teeth, and peridontal disease. No evidence of neoplasm was found.

Last follow-up visit was 4-27-61, at which time he was able to open and close his mouth and chew food better than he had for many years. In fact, he was almost approaching normal mastication.

Discussion

Bleeding from the mouth of a 50 year old patient should be considered due to cancer until proven otherwise. Adequate examination of the lining of the oral cavity, the pharynx and the tongue, all common sites of cancer, was impossible in this patient until some procedure was performed. This could have been accomplished by more simple means, however, we felt that although this patient had tolerated his deformity for 50 years, he would benefit by a procedure which would give him a functioning jaw and allow adequate examination of the oral cavity and its contents.

We felt that this could best be accomplished by a resection of a portion of the vertical ramus of the mandible and the creation of a pseudoarthrosis of the fused temporomandibular joint.

This included a considerable risk of facial nerve damage because of the distortion of the anatomical landmarks and the extreme fibrosis from the old infection. The risk, however, was justifiable in order to rule out oral cancer.

At operation the oral bleeding was found

(Continued on Page 1257)

EDITORIALS

Good From Evil

THE constant threat of catastrophic thermo-nuclear war and the preparations necessary to defend ourselves and mount a counter attack, make for an evil atmosphere. The medical profession of necessity must play a vital role in efforts to prevent war or in the preparation for war if it appears inevitable.

The care of the sick and injured is the responsibility primarily of the medical profession.

Your President has charged the Emergency Medical Services Committee with the task of informing the KSMA about the part that every doctor, regardless of specialty, should perform and his responsibility to care for the medical needs of those about him.

There are two interesting developments associated with Civil Defense preparations. One is the search by so many people for information about medical help for themselves and their loved ones. Red Cross first aid classes are mobbed. The mail is full of requests for pamphlets or first aid supplies and techniques.

The second development is the apparent determination by so many non-medical organizations, governmental or otherwise, to shift from the doctor the responsibility of advising his patients on emergency medical care. This transfer is affected by using the threadbare phrase, "doctors are too busy to do this themselves."

The medical profession now has an unusual opportunity to improve the health standards of so many people. If every doctor is willing to work at his rightful responsibility, "from seeming evil will come good."

William T. Rumage, Jr., M.D.
Chairman, Committee on Emergency Medical Services

"The Terrible Trio"

HIGHWAY murders and suicides are giving Kentucky's State Department of Public Safety a mental hangover. And so, they've come up with a campaign to "keep Kentuckians conscious"—both physically and mentally.

Kentuckians are being exposed at every turn of the wheel, the page, or the radio or TV knob to . . . "The Terrible Trio," a campaign designed to make drivers think twice, then look in the mirror to see if one of the masks of the trio is covering their face. The campaign is a real "it could be you" or "this is your life" for countless thousands of average law-abiding (they think) citizens across the State. It gives a new insight into the drinking driver (depicted as a devil on the road), the speeder (a highway Frankenstein), and the careless driver (one who fails to yield the right-of-way).

The campaign is a real eye-opener and the Department of Public Safety is to be commended for its tireless efforts to keep Kentuckians alive. Indications are, however, that their efforts have not been in vain. While highway

fatality rates across the nation have zoomed with the heavy increase in automobile traffic, Kentucky boasts a fairly even keel on her fatality chart over the past few years. But there's still a lot of room for improvement. 765 deaths last year may be a small figure when compared to the nation, but it's still 765 too many for Kentucky. Let's get behind The Terrible Trio and get them out from behind the wheels. Let's make a reality out of a new slogan . . . "Explore Kentucky . . . the most safety-conscious state in the nation."



The Terrible Trio

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IN evaluating Journal progress within the past year, we are reminded that none of this would be possible without the support of our advertisers.

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Another special vote of thanks and appreciation goes to all who have contributed time and material to the Journal. They have tried to bring you the latest in scientific knowledge and developments; they have studied and collected material for your information in socio-economic areas of importance to all physicians; and have endeavored to keep you in touch with happenings within organized medicine.

Again, let us stress a hearty and heart-felt "thank-you" to all the advertisers and contributors who make it possible for us to bring you The Journal each month.



Season's Greetings and Best Wishes

Sam A. Overstreet, M.D., Editor
and
The Journal Staff

The Richard William Dunlap Memorial Meeting Of The Kentucky State Medical Association

Roof Garden, Brown Hotel, Louisville, Kentucky September 18-20, 1961

Digest of Proceedings of the Regular Sessions of the

HOUSE OF DELEGATES

Sam A. Overstreet, M.D., Louisville

Speaker of the House, Presiding

First Session

Doctor Overstreet called the meeting to order and asked that Walter S. Coe, M.D., Louisville, give the invocation. It was reported that a quorum was present by the chairman of the credentials committee, David W. Kinnaird, M.D., Louisville. It was moved and seconded that the minutes of the 1960 meeting be accepted as published in The Journal. Motion carried.

General announcements were made by KSMA Secretary Woodford B. Troutman, M.D. Opening ceremonies were to begin at 8:45 Tuesday morning at the Columbia Auditorium, and seven of the fourteen participating specialty groups would hold meetings on Tuesday afternoon, it was announced. Doctor Troutman said the reference committees would also meet on Tuesday afternoon. He urged attendance at the President's Luncheon.

At this time the list of physicians who had died since the 1960 meeting was read and the House stood for a moment of silence in their memory. The names of the physicians, their location and date of death are as follows:

Adams, Morgan R., Shelbyville, April 24, 1961
Allen, Elijah H. Jr., Louisville, October, 1960
Arnold, Calvin G., (Emeritus), Louisville, August, 1961
Bailey, John W., Ashland, January, 1961
Bate, R. Alexander, Louisville, June 28, 1961
Beazley, Hugh C. Hopkinsville, January 29, 1961
Blackburn, S. A., Versailles, March 2, 1961
Bower, Daniel Lee, Williamsburg, July 18, 1961
Bushong, P. W., Edmonton, November 2, 1960
Cawood, B. Earl, Danville, July 11, 1961
Carter, J. G., Augusta, June, 1961
Christine, C. W., Maysville, October 28, 1960
Coe, George R., (Member), Erlanger, November 12, 1960
Crowder, Charles G., (Emeritus), Central City, May 14, 1961
Dean, Walter, (Emeritus), Louisville, March 27, 1961
Dennis, Edgar T., (Member), Louisville, January 4, 1961
Dowell, C. W., Bowling Green, May 26, 1961
Duff, Henry P., Chavies, August 31, 1961
Ewing, John T., Louisville, December 13, 1960
Garred, Mathew D., (Member), Ashland, November 3, 1960
Griffin, F. M., Hawesville, February 3, 1961
Hart, John C., (Member), Paris, June 15, 1961
Herl, M. J., (Emeritus), Louisville, June 21, 1961
Hicks, John H., (Member), Louisville, November 7, 1960
Holbrook, H. H., Greenup, January 12, 1961
Hughes, W. P., Shelbyville, January 13, 1961
Jaunzems, Alfred E., (Member), London, November 21, 1960
Kincheloe, John A., (Member), Hardinsburg, October 7, 1960
Kittinger, R. W., Cromwell, June 11, 1961
Lamb, Elzary King, (Emeritus), Franklin, April 9, 1961
Lamb William F., (Member), Franklin (In Arizona), January 25, 1961
Lawson, Hampden C., Louisville, June 23, 1961
Layman, Leslie H., Louisville, December 24, 1960
Lynn, J. F., Providence, August, 1961
Mahaffey, Herman, (Member), Louisville, October 13, 1960
Marks, Thomas M., (Emeritus), Lexington, December, 3, 1960
McCauley, W. C., (Emeritus), Versailles, June, 1961
McClure, D. E., Elizabethtown, July, 1961
Medley Lawrence H., (Member), Owensboro, March 8, 1961
Montgomery, E. W., Vine Grove, June 30, 1961
Morris, Everett, Louisville, May 17, 1961
Morris, Horace, Louisville, June 25, 1961
Newman, Hoy, (Member), Bowling Green, July, 1961
Otey, Ira G., Melber, May, 1961
Overall, A. C., (Emeritus), Lawrenceburg, September 29, 1960
Palmore, C. E., Bowling Green, July 20, 1961
Rigau, Alberto, Harlan, January 21, 1961
Scott, Thompson P., Carlisle, October 13, 1960
Scudder, Jas. W., Richmond, February 4. 1961
Seay, E. V., Salvisa, April, 1961
Seiler, Kingman G., Melber, November 2, 1960
Sherman, F. M., (Member), Owensboro, May 23, 1961
Strother, F. P., (Member), Madisonville, June 18, 1961
Thomas, F. P., (Emeritus), Hopkinsville, June 5, 1961
Todd, B. H., (Member), Bowling Green, April 19, 1961
Tracy, Edward J., Louisville, October 13, 1960
West, Edward H., (Emeritus), Williamsburg, 1961

The Speaker announced the reference committee appointments, subject to the approval of

the House of Delegates, as follows:

Reference Committee No. 1—Reports of Officers and Board of Trustees

Bruce Hamilton, M.D., Chairman, Shepherdsville
J. M. Bush, M.D., Mt. Sterling
Robert J. Hoffman, M.D., South Fort Mitchell
A. D. Steely, M.D., Bardstown
J. C. Woodall, M.D., Trenton

Reference Committee No. 2—Scientific Assembly and Medical Education

Harold Eskind, M.D., Chairman, Louisville
George F. Ballard, M.D., Harrodsburg
Thomas McElhinney, M.D., Covington
Thurman Perry, M.D., Jenkins
J. S. Williams, M.D., Nicholasville

Reference Committe No. 3—Legislative Activities

F. R. Scroggin, M.D., Chairman, Dry Ridge
R. E. Pennington, M.D., London
J. D. Handley, M.D, Hodgenville
Paul J. Sides, M.D., Lancaster
Melvin Bernhard, M.D., Louisville

Reference Committee No. 4—Public Service and Allied Professions

David Thurman, M.D., Chairman, Louisville
Harvey Chenault, M.D., Lexington
Maurice Kaufmann, M.D., Lexington
Charles F. Long, M.D., Elizabethtown
George I. Uhde, M.D., Louisville

Reference Committee No. 5—Medical Service

N. K. Kirby, M.D., Chairman, Burkesville
John Willard, M.D., Harlan
N. Lewis Bosworth, M.D., Lexington
B. F. Radmacher, M.D., Louisville
James C. Salato, M.D., Columbia

Reference Committee No. 6—Constitution and Bylaws; Special Committees

N. I. Handelman, M.D., Chairman, Louisville
Austin Bloch, M.D., Louisville
Howard Frisbie, M.D., Stanford
C. J. Shipp, M.D., Greenville
E. C. Whitaker, M.D., Berea

Reference Committee No. 7—Miscellaneous

Robert S. Tillett, M.D., Chairman, Louisville
W. E. Becknell, M.D., Manchester
J. M. Hunt, Jr., M.D., Wickliffe
James Ramsey, M.D., Frankfort
W. K. Skaggs, M.D., Taylorsville

Motion was made and seconded that the reference committee appointments be accepted as made by the Speaker. Motion carried.

The reports of the officers and committees were presented at this time and referred to the respective reference committees by the Speaker as follows:

Report of the President—Reference Committee No. 1

Report of the President-Elect—Reference Committee No. 1

Report of Speaker of House—Reference Committee No. 1

Report of Chairman, Board of Trustees—Reference Committee No. 1

William H. Bizot, M.D., chairman of the Awards Committee, presented the committee's nominations as follows:

Distinguished Service Award—A. Clayton McCarty, M.D., Louisville

It was explained that there had been no Outstanding General Practitioner Award nominees because of the apparent lack of interest in submitting nominations. Motions were duly made, seconded and carried that Doctor McCarty be presented the Distinguished Service Award and that the Award Committee's report be accepted.

Other reports were received and referred as follows:

Report of the Secretary—Reference Committee No. 1

Report of the Editor—Reference Committee No. 1

Report of the AMA Delegates—Reference Committee No. 1

Report of Executive Secretary—Reference Committee No. 1

Council on Scientific Assembly—Reference Committee No. 2

Council of Medical Education and Hospitals—Reference Committee No. 2

Council on Legislative Activities, Parts I and II—Reference Committee No. 3

Council on Medical Services—Reference Committee No. 5

Council on Communications and Public Service—Reference Committee No. 4

Council on Allied Professions and Related Groups—Reference Committee No. 4

Board of Directors, Rural Kentucky Medical Scholarship Fund—Reference Committee No. 5

Advisory Committee to Selective Service—Reference Committee No. 5

Report of Woman's Auxiliary—Reference Committee No. 7

Representative, Advisory Committee and Maternal and Child Health, State Department of Health—Reference Committee No. 7

Kentucky Health Council—Reference Committee No. 4

Advisory Committee to the Editor—Reference Committee No. 6

Professional Relations Committee—Reference Committee No. 6

Committee on Third Party Medicine—Reference Committee No. 6

Committee to Study Constitution and Bylaws—Reference Committee No. 6

County Society Officers Conference Committee—Reference Committee No. 6

KSMA Representative to Conference of Presidents and other Officers of State Medical Associations—Reference Committee No. 7

KSMA Representative, U. of K. Chapter, Student AMA—Reference Committee No. 7

KSMA Representative, U. of L. Chapter, Student AMA—Reference Committee No. 7

KSMA Representative, State Practical Nurses Advisory Committee—Reference Committee No. 6

KSMA Representative, State T. B. Coordinating Council—Reference Committee No. 4

McDowell Home Committee—Reference Committee No. 7

Medicolegal Administrator—Reference Committee No. 7

Building Committee—Reference Committee No. 7

Board of Directors, Kentucky Physicians Mutual, Inc.—Reference Committee No. 5

New Business

The new business was then presented to the House and referred to reference committees by the Speaker as follows:

(A) Resolution of the Fayette County Medical Society concerning the Indiana Plan—Reference Committee No. 5.

(B) Resolution of the KSMA Board of Trustees concerning policy on osteopathic physicians—Reference Committee No. 2.

(C) Resolution of the Campbell-Kenton Medical Society concerning the AMA's Educational Council for Foreign Medical Graduates program—Reference Committee No. 2.

(D) Resolution of the Campbell-Kenton Medical Society concerning the internship program—Reference Committee No. 2.

(E) Resolution of the Campbell-Kenton County Medical Society concerning the status of the Kentucky Indigent Care Program—Reference Committee No. 5.

(F) Resolution of the Muhlenburg County Medical Society on the general subject of medical discipline—Reference Committee No. 1.

(G) Resolution of the Daviess County Medical Society on the subject of the Indiana Plan—Reference Committee No. 5.

(H) Resolution of the Daviess County Medical Society concerning the indigent care program— Reference Committee No. 5.

(I) Resolution of the Laurel County Medical Society on the general subject of Medical discipline—Reference Committee No. 1.

Doctor Overstreet then designated meeting places for the Nominating Committee for General Officers and the five Trustee District nominating committees. He stated the Nominating Committee would make known its recommendations for the various state offices on Tuesday morning at the close of the first scientific session. The House was reminded that additional nominations could be made from the floor at the second session of the House on Wednesday night, after the nominations of the above committees had been read.

Robert C. Long, M.D., Louisville was recognized at this point. He urged the members to attend the meeting on Thursday night at which Edward Annis, M.D. Miami, Florida would speak. It was noted that Doctor Annis was a nationally known speaker for medicine and had successfully debated labor leader Walter Reuther and Senator Hubert Humphrey on television.

The Speaker expressed his appreciation to the members of the House for their enthusiastic cooperation and attention during the evening.

There being no further business, a motion was duly made, seconded and carried that the meeting adjourn at 10:30 p.m.

Second Session

The second session of the Kenucky State Medical Association House of Delegates was called to order on Wednesday, September 20, 1961 by the speaker, Sam A. Overstreet, M.D., in the Roof Garden of the Brown Hotel, Louisville, at 7:15 p.m. The invocation was given by Charles Long, M.D., Elizabethtown, after which a quorum was reported present by the chairman of the credentials committee, David W. Kinnaird, M.D., Louisville.

Doctor Overstreet announced the tellers committee as follows:

Carroll Robie, M.D., Louisville
Harry A. Pfingst, M.D., Louisville
Maurice Kaufmann, M.D., Lexington
Paul J. Sides, M.D., Lancaster
E. M. Howard, M.D., Harlan

It was explained that the purpose of this was to insure proper voting procedures.

The chairman of the Board of Trustees, J. M. Stevenson, M.D., presented the final report of the Board as follows:

"The Board submits the following resolution, passed at its September 20 meeting:

WHEREAS, the 1961 Annual Meeting of the Kentucky State Medical Association has been well attended and generally accepted as being one of the outstanding meetings that this Association has held, and

WHEREAS, the House of Delegates desires to express its appreciation to the Council on Scientific Assembly, to our guest speakers, and those who cooperated in developing an outstanding scientific program, and

WHEREAS, the fourteen specialty groups who co-operated so well and worked tirelessly to make these meetings held in connection with the annual session a success, and

WHEREAS, the Columbia Auditorium, the Brown Hotel, the public press, the Louisville Chamber of Commerce, along with many other organizations and individuals have cooperated to help make his meeting successful,

NOW THEREFORE BE IT RESOLVED that the House of Delegates of the Kentucky State Medical Association go on record as expressing its deep appreciation to all individuals and organizations that had any part in developing and presenting the 1961 Annual Meeting.

Mr. Speaker, I move the adoption of this resolution. The motion was duly seconded and carried.

The reports of the reference committees were then presented.

REFERENCE COMMITTEE NO. 1

Bruce Hamilton, M.D., Chairman
Reports of Officers and Board of Trustees

Report of the President

This past year has been most interesting and instructive to me. I have gained an insight into national, state and local politics, the care of indigent, health and hospital insurance, the problem of the third party in medicine, the points on which our policy

agrees and disagrees with that of the allied professions, many problems of both the state and county medical societies, and the strong and the weak points of the practice of medicine in Kentucky. I feel that in the future I shall be able to think more clearly on these subjects and will be more tolerant in my judgements of those who are trying to solve them.

I have not been able to travel as much as I should have liked but I have tried to be present at all meetings of importance where the policies of KSMA were under consideration. These have included the meetings of the Board of Trustees and of a number of committees.

I have attended the annual dinner with our Senators and Congressmen in Washington, D.C., in February which was a most pleasant and profitable affair. I hope that each of you can make this journey at least once. Your perspective on our national government will be broadened and some of your ideas may be changed so that you will be more patient with the KSMA and AMA in their handling of political matters. The County Officers Meeting in Lexington in March presented a fine program of excellent speakers. In June I was at the AMA Meeting in New York where I saw the House of Delegates and the Reference Committees in action. My stay there was interrupted by another trip to Washington where I was a member of a committee of KSMA that went to see the Secretary of Health, Education and Welfare regarding the transfer of public land for use as a chiropractic children's clinic and hospital in Louisville. I have also attended a number of banquets and other meetings as the KSMA Representative.

I asked the nominating committee last year to give me able and willing vice-presidents and they did. I am deeply indebted to them for the many times they have cheerfully substituted for me and I am sure that they have been most efficient representatives of KSMA at the meetings of our neighboring state medical societies which they attended.

It has been a good year and a busy one for the Association. The Headquarters Building was dedicated and is under construction, our key man system has been shaken down and is ready to flex its muscles, we have grown and now have three delegates to the AMA meetings. I wish to thank the members of the Board of Trustees, the many committees and the Headquarters Staff for their work, often beyond the call of duty and to the many individual members of the Association for their suggestions and criticisms throughout the year.

Richard G. Elliott, M.D., Lexington
President

Recommendations, Reference Committee No. 1

The Reference Committee No. 1 carefully considered the report of the President to the 1961 session of the House of Delegates. We recommend that the House of Delegates accept his report and in so doing, that they express the sincere thanks of the KSMA for his valuable service.

Mr. Speaker, I move the adoption of this section of the report. Motion was seconded and carried.

Report of the President-Elect

As President-Elect of the Kentucky State Medical Association I particularly appreciated the opportunity of association with the President, Doctor Richard Elliott, Lexington, Kentucky, and also contacts with the officials of Kentucky State Medical Association and its membership. During the year I attended and participated in the following events in the official capacity of President-Elect.

French Lick, Indiana, State Medical Association, October 3, 4, 5, 1960

Executive Committee Board of Trustees, KSMA, Louisville, October 19, 1960

Council on Scientific Assembly & Arrangements, KSMA, Louisville, November 10, 1960

AMA Annual Meeting in Washington, D. C., November 27, 1960

Council on Medical Service, KSMA, Louisville, January 19, 1961

AMA Legislative Conference, Chicago, Illinois, March 18, 19, 1961

Board of Trustees Meeting, KSMA, Louisville, January 26, 1961

KSMA Executive Committee Board of Trustees, Louisville, March 23, 1961

KSMA Officers' Conference, Lexington, April 5, 1961

KSMA Advisory Commission to Blue Shield, Louisville, May 18, 1961

Executive Committee Board of Trustees, Legislative Conference, Louisville, April 27, 1961

Council on Scientific Assembly, KSMA, Louisville, June 13, 1961

Council on Medical Services, KSMA, Louisville, June 15, 1961

AMA Annual June Meeting, New York, June 26, 1961

KSMA Board of Trustees, Louisville, July 27, 1961

AMA Public Relation Institute, Chicago, Illinois, August 31 and September 1, 1961

G. L. Simpson, M.D., Greenville
President-elect

Recommendations, Reference Committee No. 1

Mr. Speaker, I move that the report of the President-Elect be adopted. Motion was seconded and carried.

Report of the Speaker

At the 1960 meeting of this House of Delegates you rewrote the Bylaws and changed the committee structure of the Association. The name of the Council was changed to the Board of Trustees, thus freeing the term to be used in another capacity.

The new Bylaws provided for the establishing of six different councils covering the six main categories of the Association's committee work. The activities of these councils and committees are carefully delineated in Chapter 7 of the KSMA Bylaws, a copy of which is in your folder. This year the Reference Committees, in considering the reports of the various committees of the Association, will have the benefit of recommendations of the council under which the committee serves along with the recommendations of the Board of Trustees.

Every care has been taken in trying to organize this meeting so as to bring the maximum efficiency to your work with a minimum amount of effort to you. Please call on your speaker, vice speaker, other KSMA officers or the members of the headquarters staff when you feel we can be of service to you.

Sam A. Overstreet, M.D.
Speaker of the House of Delegates
Kentucky State Medical Association

Recommendations, Reference Committee No. 1

The Committee recommends in accepting this report that the KSMA express its deep appreciation to the Speaker, Sam Overstreet, M.D., for the effective and helpful manner in which he has discharged his duties.

Mr. Speaker, I move the adoption of this section of the report. Motion was seconded and carried.

Report of the Chairman of the Board of Trustees

The interim governing body of the Association has completed its first full year as the Board of Trustees, having formerly been known as the Council. During this 110th year in the life of the Association, the Board of Trustees held five meetings at which 101 members attended, spent 898 man hours transacting the Association's business and drove 23,094 miles to attend these meetings. (This does not include the organizational meeting of the Board held September 22, 1960.)

The Executive Committee held four meetings at which there was an attendance of 24 who spent 105 man hours in session and drove 3,062 miles to the meetings. These figures, we believe, give you some idea of the extent to which the men you have elected to compose your Board of Trustees are dedicated to their work and the amount of sacrifice that they make in the discharging of their duties.

It is doubted by many observers that this body, during the entire 110 years of the life of the Association, has ever been called on in any one year to deal with more difficult problems and make more important decisions than the members of this Board. It has been a distinct honor for me, as chairman to preside over this group and I am deeply grateful for the cooperation of all the members and officers of the Association during this difficult year.

Obviously, it is not feasible for the Board and the Executive Committee of the Board to report to you in detail all of the actions it took in the total of ten sets of minutes that are reported on 120 pages. This report, therefore, will touch on the highlights of the activities of the Board during the past year in the interest of saving time. It should be remembered, however, that any member of the Association is welcome to read any of these minutes, which are kept on file in the headquarters office, at any time.

First Meeting—Woodford B. Troutman, M.D., temporary chairman, called the organizational meeting of the Board to order at 12:50 p.m. on Thursday afternoon, September 22, the last day of the 1960 Annual Meeting. Doctor Troutman asked for nominations for the 1961 chairman; and James M. Stevenson, M.D., Brooksville, Kentucky was nominated and elected by acclamation.

New members of the Board were then recognized. They were Gaithel L. Simpson, M.D., Greenville, president-elect; Foster D. Coleman, M.D., Louisville, vice-president from the central district; Wendell V. Lyon, M.D., Ashland, vice-president from the eastern district and J. Thomas Gilbert, M.D., Bowling Green, vice-president from the western district. Newly elected members of the Board were Dexter Meyer, M.D., Covington, eighth district and Hubert Jones, M.D., Berea, eleventh district. Robert C. Long, M.D., Louisville, re-elected for another two years as a delegate to the AMA, was recognized, along with Carlisle Morse, M.D., Louisville; John Pepper Glenn, M.D., Russellville; Douglas E. Scott, M.D., Lexington; and Keith P. Smith, M.D., Corbin, who were re-elected trustees.

Wyatt Norvell, M.D., New Castle, trustee for the seventh district, was named vice-chairman of the Board. The Board completed the formation of the Executive Committee, electing Doctors Morse and Thomas Meredith, M.D., Harrodsburg, as the two members from the Board who, together with the president, president-elect, chairman of the Board, vice-chairman and secretary, make up the membership of the Executive Committee.

The Board then discussed plans for the 1961 County Society Officers Conference and voted to extend Congressman John C. Watts, representative from the sixth district, Kentucky, to be the featured speaker.

Clarification of the function of the KSMA Technical Advisory Committee to the Governor's Advisory Council on Indigent Care was undertaken.

The Board voted after reviewing the House of Delegates' action on the proposal to proceed with the erecting of a new headquarters office building, to continue the committee that made the report as the building committee, that this committee be authorized to purchase the lots that were then under option on which to build the new building, and that the architects of Nevin and Morgan be employed to draw the plans for the building.

Recommendations from the KSMA's Committee for Contributions to the AMEF, relating to more vigorous promotion, were read and approved.

It was decided that the Executive Committee would meet on October 19 and make nominations for the new committees and councils, as provided under the new bylaws and that the Board of Trustees would meet on October 20 to act on these recommendations.

Second Meeting—The second meeting of the Board was held October 20 at the Kentucky Hotel. The Board approved recommendations made by its Executive Committee of nominees for each of the two vacancies on the State Board of Health, created by terms expiring on December 31, 1961.

The Board of Trustees was told that the Executive Committee had worked many long hours in setting up the personnel for the new committee and council structure as approved by the House of Delegates at its meeting in September. It was explained that under the new system the Executive Committee served as a nominating committee and that the members of the councils, committees of the councils, and other committees nominated by the Executive Committee would be elected by the Board of Trustees. The lists were submitted and individually considered and acted on by the Board of Trustees. (The list of these committees will be found in the House of Delegates manual.)

The Board of Trustees then heard an interim report on the progress made by the KSMA Building Committee. In this connection, a recommendation was made from the chairman of the committee on postgraduate medical education that, when the new building was completed, the executive director of the postgraduate medical education office and his secretary be moved from the downtown office to the new building. This recommendation was approved.

The Board then heard a progress report on the implementation of the indigent care program. It also considered the request of H. L. McPheeters, M.D., state mental health commissioner, relating to the limited license problem. Because of incomplete information, final action was not taken.

The Board approved a statement explaining the circumstances under which services of the KSMA's legal counsel would be offered to its members free, and when it would not.

Third Meeting—The Board of Trustees held a call meeting Sunday, December 11, 1960 at 10:45 a.m. in the Brown Hotel. The meeting was held in connection with a conference for KSMA legislative key men. Purpose of the call meeting was to vote on two recommendations from the Council on Legislative Activities. The first was that the Association make a stated contribution toward the expenses of each KSMA legislative congressional district key man attending the Washington congressional dinner and that the president of the Woman's Auxiliary to KSMA be included in this list. The recommendation was approved.

The second request of the Council on Legislative Activities was that the local county legislative key men be elected by the county medical society instead of being appointed. This recommendation was also accepted.

Fourth Meeting—The fourth meeting of the Board

was held January 26, 1961 at the Kentucky Hotel. The primary purpose of the meeting was to hear representatives of the county medical societies and other medical organizations express their views on the operation of the indigent care program. After nearly six hours of presenting statements, questions and answers and discussion generally, the Board of Trustees directed the Technical Advisory Committee of the KSMA to the Governor's Council on Indigent Care to recommend to the Advisory Council "that the normal going fee of the physicians in their local communities be charged for services rendered under the indigent care program and that physicians be paid on a percentage basis out of funds available for physicians under the program, after the end of each month." The Board then passed a statement commending the KSMA member on the Advisory Council to the Governor on Indigent Medical Care and the members of the Technical Advisory Committee.

In the closing minutes of the meeting, the Board considered suggestions relative to resisting legislative proposals that would expand the Social Security Act, so as to include compulsory coverage of the aged; advocated the early scheduling of district trustees meetings; encouraged its members to attend the Washington dinner, and filled vacancies on two committees.

Fifth Meeting—The KSMA Board of Trustees met at the Phoenix Hotel, Lexington, in an eight-hour meeting, April 5 the evening preceding the 1961 County Society Officers Conference.

Following a discussion, the 1961-62 budget was accepted by the Board as presented by the Budget Committee and recommended by the Executive Council.

"Go ahead" approval was given to the Building Committee after a detailed analysis and report by the Building Chairman, George Brockman, M.D., Greenville.

Gaithel Simpson, M.D., Greenville, KSMA President-elect, reported to the Board on a legislative conference that had been held in Chicago on March 18 and 19. Following this report, the Board recommended that the KSMA Headquarters staff devote more of its time to legislative matters.

By increasing its membership to over 2,000 AMA members, the KSMA qualified for a third delegate and alternate. The Board accepted the recommendation of the Executive Committee in naming Doctor Brockman as delegate and John Quertermous, M.D., Murray, as alternate.

A report on the activity of the KSMA Technical Advisory Committee to the Governor's Advisory Council on Indigent Care was made by the chairman, Clyde Sparks, M.D., Ashland. After a lengthy discussion by the Board and guests, it was recommended that the KSMA support in full the provision of the Kerr-Mills bill.

Confirmed as members of the newly formed Highway Safety Committee were Doctors Keeney, chairman, Arnold Griswold, William Keller, all of Louisville, Delmas M. Clardy, Hopkinsville and Timothy Swartz, Lexington. Also approved was the request of the Public Health Department on holding Well Child Conferences throughout the state, subject to the approval of each County Board of Health.

Nominations were submitted to the Governor for the vacancy existing on the State Health Board. After listening to a presentation by U.S. Treasury Agents, the Board adopted a resolution opposing non-ambulatory treatment of narcotic addicts.

The Board heard an appeal by a UMWA representative in Pike County who wanted the Board to arbitrate the differences between the members of the Pike County Medical Society and the UMWA physicians. Following the hearing and discussion, the KSMA attorney was authorized to inform the UMWA physicians that the Board had no authority to dictate policy to the Pike County Medical Society due to its autonomy.

Other actions included the tabling of a recent request concerning the licensing of foreign medical graduates. Instruction was given the KSMA legal counsel to inform the Greater Cincinnati Radiological Society that it is the Board's opinion that it is not ethical for a physician to be employed by a hospital since a hospital (or any corporation) cannot practice medicine in Kentucky, and that the physician's position ultimately becomes unethical, under Section 4 of the "Principles of Ethics."

Sixth Meeting—The sixth meeting of the Board, held July 27, 1961 at the Brown Hotel, was called to order shortly before 10 a.m. and was adjourned at 7:45 p.m. All of the members of the Board were present but six and there were 15 guests in attendance. The report of the Kentucky delegation to the 1961 AMA Annual Meeting was given by W. Vinson Pierce, M.D., Fort Thomas. He complimented the new delegate, George F. Brockman, M.D., on his good work at his first meeting.

The Board voted to make the new KSMA Committee on Highway Safety a part of the Council on Communications and Public Service; elected James Davis, M.D., Louisville, to succeed Robert McKinley, M.D., Glasgow, as a member of the KSMA Committee on Postgraduate Medical Education and the scientific program committee; authorized the appointment of a committee to handle surplus property sales that the Association might have in the way of office equipment and voted to pay in advance the transportation of an Annual Meeting guest speaker who had made a special request.

The Board then heard the chairman of the building committee, George Brockman, M.D., Greenville, give an interim report. He stated that the foundations for the new building had been poured, partitions were up in the lower floor and brick was now being applied, and that some steel was being put in place. He brought the Board up to date on the negotiations with the Metropolitan Sewer District for an easement across the front of the property and told of the recommendations that KSMA historian, Emmet F. Horine, M.D., had made. On Doctor Brockman's recommendation, the Board authorized the investment committee—of which Keith P. Smith, M.D., Corbin, is chairman—to borrow whatever funds were needed to complete construction of the building.

At the conclusion of Doctor Brockman's report, Chairman Stevenson explained to the Board that, at the meeting of the Executive Committee of the Board immediately following the ground breaking on May 21, the Executive Committee voted to purchase two additional lots adjacent to the property the Association already owned because it was felt this would protect the Association's investment and provide for possible future expansion. Since the land was appreciating in value, no loss would likely be anticipated. The Board voted without dissent to approve the action of the Executive Committee to purchase the two additional lots at the cost of $6,000 each.

It was explained that under the new bylaws adopted by the House of Delegates at the 1960 Annual Meeting, all councils and committees of councils and standing committees would make their reports, at least six weeks in advance, to the House of Delegates through the Board of Trustees. The Association's legal counsel was called on at this time to suggest uniform procedures for the presentation of these reports and the reporting of the Board's recommendation on each one. It was agreed to follow the counselor's recommendation.

Russell Teague, M.D., state health commissioner, explained that the State Board of Health had passed a resolution calling for the introduction of an amendment to the Medical Practice Act, relating to the liberalizing of the law with respect to foreign gradu-

ates. He stated that Carl Fortune, M.D., Lexington, member of the Board and chairman of the Committee for this matter, would explain the Board of Health's position. Following lengthy consideration, the Board of Trustees took no action on the matter but authorized the commissioner to send appropriate explanatory materials to all members of the Board at an early date, so that this information could be studied before the Board would again consider the matter at its September 18 meeting.

At this time the Board took up the report of the six councils and the various committees. The reports of the councils and committees were presented by the committee or council chairman of its respective group. Consideration of these reports required four and a half hours. Action of the Board on each one of these reports will be found at the conclusion of the report that is presented to the KSMA House of Delegates.

The full 19-page minutes of the July 27 meeting are on file in the headquarters office and available to any KSMA member who wishes to read them.

J. M. Stevenson, M.D., Brooksville
Chairman
KSMA Board of Trustees

Supplemental Report, Board of Trustees

At the meeting of the Board of Trustees this afternoon, the matter of whether to amend the Medical Practice Act so as to liberalize the provisions, with relation to licensing the foreign graduate, was presented. Following a full discussion by the Commissioner of Health and members of the Board of Trustees, it was voted not to take any action at this time and to continue to study the problem.

Recommendations, Reference Committee No. 1

The Committee carefully considered this report. It would like to call attention to a statement on Page 4 which is as follows:

> "The Board approved a statement explaining the circumstances under which services of the KSMA's legal counsel would be offered to its members free, and when it would not."

It is recommended that a statement explaining this material again be presented to the members of the KSMA in whatever manner it would be most easily accomplished.

Again we would like to call attention to the tremendous amount of work done by the Board of Trustees in behalf of the KSMA and express our sincere appreciation for their efforts.

Mr. Speaker, I move the adoption of this section of the report. Motion was seconded and carried.

Report of the Secretary

Among the more important actions this House took at its 1960 meeting was the adopting of a new organizational structure and pattern of activity for the committees and councils of the KSMA. The wisdom of your action last year will be demonstrated most adequately, we believe, in several ways before this meeting is over.

The six councils, under which the Association's "program activity" has been grouped, held 12 meetings. Fifty-eight members spent 239 hours in these meetings and traveled 9,134 miles in order to do this work for you.

The 33 committees under these six councils held 41 meetings, attended by 284 members who spent 1,058 hours in their meetings and traveled 38,743 miles in serving our Association.

This was all done between November 1, 1960 and July 27, 1961. A few committees have met since July 27 when the councils and committees reported to you through the KSMA Board of Trustees, as provided by the by-laws. Some of these committees will have supplemental reports for your consideration.

We believe you will agree that the new method of reporting to you has been vastly improved. Although the page volume of your reports this year has been greatly reduced, yet the amount of work to be reported on has substantially increased.

When you consider these committee reports, you will not only have the recommendations of committees but the reaction of the council of which the committee is a part and also that of the Board of Trustees.

Finally, we believe you will find that there is most substance, depth and scope to the reports, demonstrating more careful planning and effort in more areas of interest and concern to our members.

To those of us who have observed the Association's many activities at close range over some years, we find these developments very encouraging. This progress can not be a cause for complacency on our part. This simply means that we are "tooling up," so to speak, to meet the many problems that face organized medicine in which all of us must participate and accept responsibility.

When completed, the new KSMA building will provide comfortable and efficient facilities for our members serving on the various KSMA committees and councils as they spend their long hours in behalf of the welfare of the membership as a whole. Necessary records, material and information will be immediately available to the members of councils and committees as they meet. Moreover, the enlarged headquarters will contribute materially to the efficiency of our staff.

The KSMA must maintain an intense interest in legislative matters, in both the State Legislature and in Congress, and expand its member participation. Your Council on Legislative Activities has been very active in preparing legislative proposals in the public interest that must be approved by the Board of Trustees for introduction in the 1962 Kentucky Legislature. In addition, your legislative council is preparing for the showdown fight in Congress on the King Bill—HR 4222—next year, which will demand our best if we are to win.

Kentucky medicine was well represented at the White House Conference on Aging and at the House Ways and Means Committee hearings on the King Bill—HR 4222—last month. On at least three occasions during the past associational year, the offices of both senators and all eight Kentucky congressmen were personally contacted by groups of representatives of the KSMA. These contacts are very valuable.

Another activity bringing recognition and credit to the Association was the Regional Medical Editors Conference, presented by The Journal of KSMA. More than 70 medical editors from 28 states extending to both coasts attended this conference. Support of the conference by William R. Willard, M.D., vice-president of the University of Kentucky Medical Center, is gratefully acknowledged.

In line with its policy of seeking proper distribution of medical care in all the rural areas, the KSMA placement service, working with the people of McKee, Kentucky, the Rural Kentucky Medical Scholarship Fund and the Sears Foundation, helped find an M.D. and participated in the establishment and dedication of a new office building for him.

A new KSMA Committee on Highway Safety has been established. It is actively cooperating with the State Department of Public Safety and the Governor's Highway Safety Advisory Committee. We believe the Association can and will render a very worth while public service in this area.

Among the more preplexing problems the Association's leadership has faced during the past year was assisting in the implementation of the State's new indigent-care program and the Kerr-Mills program for the

aged. Unfortunately for all, it was necessary for both of these to start at the same time. We are certainly indebted to G. L. Simpson, M.D. for the many long hours he has given to the program. As you are aware, improvements in these programs are being made constantly. Although faults may be detected, you are urged to help correct these errors and cooperate to the best of your ability with these programs.

While the following matters will be fully reported on later this evening, we want to commend the KSMA Advisory Commission to Blue Shield on its part in urging substantially increased benefits by Blue Sheild which is now being offered; the effective service being rendered by the KSMA placement service and the Rural Kentucky Medical Scholarship Fund; the establishment of a Student AMA Chapter at the University of Kentucky Medical Center and the services offered by the Postgraduate Medical Education Fund.

In closing, I must again express my deep appreciation to the officers, members of this House, members of the Board of Trustees, committees and councils for your excellent work. My thanks to the members of the headquarters staff for their cooperation with my office.

Woodford B. Troutman, M.D.
KSMA Secretary

Recommendations, Reference Committee No. 1

This report was carefully considered by our Committee and we would like to express our appreciation for the efforts of the Secretary and the various Councils.

Mr. Speaker, I move the adoption of this section of the report. Motion was seconded and carried.

Report of the Editor of The Journal

During the 1960-61 year two new departments have been added to the Journal. On the recommendation of the KSMA Advisory Commission to the Kentucky Blue Shield Plan a monthly question and answer page which covers pertinent developments in the field of voluntary medical care plans has been added. In addition, a tax page written by Mr. William E. Rudd, a member of the KSMA Headquarters Staff, has appeared every three months.

You will appreciate the fact that a journal such as ours is printed at a very considerable expense. The cost of publication is borne by our advertisers. These firms who support our publication through the purchasing of advertising space are carefully selected. We wholeheartedly recommend these firms to you and urge your patronage of them.

Response to the Regional Medical Editors Conference our Journal presented in Lexington last October was most gratifying. The Journal wishes to acknowledge the contribution made to the success of this conference by William R. Willard, M.D., Vice President of the University of Kentucky Medical Center.

We want to express appreciation to our co-editor, George W. Pedigo, M.D., our departmental editors and our board of consultants for their excellent, faithful and prompt contributions to the Journal.

Sam A. Overstreet, M.D., Louisville
Editor of The Journal
Kentucky State Medical Association

Recommendations, Reference Committee No. 1

Mr. Speaker, we would like to commend the Editor of the Journal for the excellence of the Journal and to express our thanks for his efforts.

Mr. Speaker, I move the adoption of this section of the report. Motion was seconded and carried.

Report of the Treasurer

The Committee considered the report of the Treasurer and again were impressed with the large volume of work involved and the completeness of this report.

Mr. Speaker, I move the adoption of this section of the report. Motion was seconded and carried.

Report of the Delegates to the American Medical Association

One of the principle responsibilities of the delegates to the American Medical Association is that they shall report back to the State Association or to the specialty groups which they represent concerning the actions taken by the House of Delegates of the A.M.A.

In recent years the delegates from the Kentucky State Medical Association to the A.M.A. have given their reports in the Journal of the K.S.M.A., as soon as possible following each session of the House of Delegates of the American Medical Association. The reports for the last two meetings of the A.M.A. may be found in the issues of the K.S.M.A. Journal for January, 1961 and for August, 1961. We do not believe that these reports require further elaboration at this time.

Some comments concerning the activities of your delegates during the past year may be in order.

For the first time the number of K.S.M.A. members who belong to the A.M.A. has passed the two thousand mark and we are happy and proud to remind you that we now have three delegates to the A.M.A. This fact should be especially gratifying to all of us since each of the three geographical areas of our State Association is now represented.

The Board of Trustees of the K.S.M.A. selected George Brockman, M.D. of Greenville, Kentucky to be the third delegate at the Annual Meeting in New York City June 25-30. Doctor Brockman displayed exceptional zeal and aptitude in carrying out the duties and responsibilities of his new office, and amply vindicated the judgment of the Board of Trustees in selecting him.

John Quertermous, M.D., of Murray, Kentucky was selected as Doctor Brockman's alternate. He, too, demonstrated his interest in the proceedings of the House of Delegates by faithful attendance at the business sessions of the House, and at the reference committee hearings, as did Vernon Pace, M.D., the alternate Delegate from Paducah, Kentucky.

George Archer, M.D., of Prestonsburg, Kentucky, who is the other alternate delegate was present at the Clinical Session in Washington, D.C., but because of illness, was unable to attend the New York Meeting. We are glad to report that he has recovered from his illness and that he is now able to continue to serve as a valuable member of the Kentucky delegation.

The effectiveness of your delegates in representing our State Association has been helped immeasurably by the presence and interest of the alternate delegates at the meetings. Many other members of our State Association and of our K.S.M.A. Headquarters Staff have given generously of their time, to attend reference committee meetings and to participate in the discussions at these hearings.

Both President Elliott and President-elect Simpson were present at the sessions at the House of Delegates at the New York Meeting this year.

A caucus of the delegates, alternate delegates and other interested members of the Kentucky State Medical Association has been held two or more times at each meeting in the past few years, in order to discuss the matters which are to be considered, and to arrive at an opinion as to how we should vote on each issue.

Whenever we have had specific directives from our

State Association concerning any matter, your delegates have always acted according to such instructions.

The large volume of business at any session makes it impossible that every delegate shall have been informed in advance as to how he shall vote on every issue. At the New York Meeting this year for example, more than one hundred resolutions were introduced, to say nothing of the many reports and recommendations of the Board of Trustees and of the various Councils and Committees of the A.M.A.

In all matters wherein your delegates have not been previously instructed by our State Association, we have tried to act in the best interest of our profession, and of the public whom we serve.

During the past year, your delegates were pleased to note that many of our Kentucky physicians were informing themselves concerning matters to be considered at the meetings, and were expressing to the delegates their own views on these subjects as well as the views of the organizations which they represented.

In recent years we have frequently heard the criticism voiced, both by members of our profession and by others outside the profession, that the American Medical Association is an "ivory tower" organization, which is neither aware of the opinions of its members at the "grass roots" level, nor is it concerned over such opinions. We often hear it stated that the official policies of the A.M.A. do not conform to the needs and wishes of the majority of its members in many important areas.

Your delegates from Kentucky most emphatically do not agree with these accusations. We have found that the House of Delegates of the A.M.A. is one of the most truly democratic bodies of any which represents an important group of our citizens in this country.

If the majority of the physicians in our country should disagree with any official policy of the A.M.A., such policy can readily be changed to conform to the wishes of the membership of the A.M.A., if a sufficient number of the Constituent Associations so instruct their delegates.

In conclusion, we again wish to thank the members of this House of Delegates for the confidence which you have expressed in us by electing us as your delegates, and for the privilege and honor of serving you in this capacity.

We would indeed be remiss if we failed to acknowledge our gratitude to our Executive Secretary and his staff for the innumerable services they have rendered, to help make our work more efficient and less burdensome.

George Brockman, M.D., Greenville
Robert Long, M.D., Louisville
W. Vinson Pierce, M.D., Covington
Delegates to the A.M.A.

At this point, Doctor Pierce expressed his appreciation for the opportunity of serving as AMA delegate for the past eight years. He stated it had been a challenging and rewarding experience.

Recommendations, Reference Committee No. 1

The Committee considered the report of the Delegates to the A.M.A. and found an excellence of work which must be rewarded by special thanks. In addition we would like to especially express our appreciation for the unrelenting efforts of W. Vinson Pierce, M.D.

Mr. Speaker, I move the adoption of this section of the report. Motion was seconded and carried.

Report of the Executive Secretary

Under the new committee structure voted by the House of Delegates at the 1960 Annual Meeting, associational committee activity has increased approximately 15% despite the fact that there were unavoidable delays incident to implementing the system.

In order to give you a more accurate picture of what the members of the various committees, councils and the Board of the Association are doing for you this year, we kept certain records. We learned there were 463 individual members of KSMA who spent more than 2,300 hours in 64 formal meetings on association business. In order to do this, these members traveled an estimated 74,033 miles. This was accomplished between November 1, and July 31.

Not included in the above is the regular Monday morning meeting at 7:30 in my office with our Editor of the Journal, the Associate Editor and Assistant Managing Editor. Also not included are the many time consuming conferences members spent informally with staff members on scholarship and placement matters, planning various conferences sponsored by the KSMA or the conferences that we cooperated with, legislative and indigent care matters and developments incident to the erection of the new building.

As we, the members of the Headquarters Staff, review these revealing figures and recognize perhaps more than some of you, the dedication, devotion and sacrifice in time and money these doctors made in order to better serve their profession and the public, naturally we feel a great sense of pride and inspiration in having an opportunity to staff these meetings for you.

While on the subject of meetings, we should report that there are many Kentucky organizations and governmental agencies active at the state, regional and county level who have an interest in matters relating to the health and safety of our people. Obviously, a service conscious state medical association such as ours wishes to keep abreast of the developments and offer such assistance as is possible. KSMA staff members represented the association at more than 100 of these meetings, large and small. Certainly, more and more of our population are learning that KSMA has an intense and continuing interest in the welfare of our people.

The ever-increasing tempo of developments in the area of socio-economic medicine, a field only recently recognized, keeping informed on the most efficient procedures for associational activities, learning pitfalls in procedures formerly accepted as correct, make it necessary for staff men to attend certain regional and national meetings in order to render a more efficient service. During the past year, the three executive members of the staff attended 25 such meetings, many of which were in adjoining states.

Your staff, under the direction of the appropriate authority, handled, promoted and developed the County Society Officers Conference, two legislative key men conferences, the Rural Health Conference, the Athletic Injury Conference, and the Regional Medical Editors Conference in Lexington, the Annual Senior Day, and the New Member Indoctrination Luncheon.

In the field of health education, exhibits were presented and manned at the Kentucky State Fair, Kentucky Education Association Annual Meeting, the Kentucky Congress of Parents and Teachers Association, The Kentucky Home Show and the Campton Health Fair. Two other important activities in this area included the Diabetes Detection and Education Drive and Immunization Week.

The State's new indigent care program has absorbed much staff time, as the Association seeks to discharge this obligation in this highly important area. Our Director of Field Services will average a meeting a month, working with the KSMA Technical Advisory Committee and the Governor's Advisory Council on Indigent Care. He has fulfilled numerous speaking engagements before medical groups discussing the program.

Two of our most important staff activities continue to be collecting and meeting deadlines for the publication of our 100-page monthly Journal and for our

evergrowing Annual Meeting. These two activities absorb a substantial amount of staff time each year as we seek to have the best possible Journal and Annual Meeting.

Under miscellaneous matters, the staff, under the supervision of proper authority, writes the Secretary's Letter and Newscaps, news releases and sundry promotional material. We have spoken at civic club meetings and other public groups. It is conservatively estimated that during the past year, your staff members saw approximately 2,000 people in the office, handled more than 7,800 telephone calls and got out approximately 65,000 pieces of mail.

This brief report is intended to give you a quick review of our activities. It cannot begin to cover all of them. In so doing, we do not want to overlook the highly substantial but less dramatic activities of other members of our staff who perform so well and often behind the scenes. They are as much a part of the first team as any of the members of our staff and render a most vital service in our operation.

To the officers, members of the House of Delegates, Board of Trustees and committee members, we of the staff want to express our sincere appreciation for your many kindnesses, cooperation and for the opportunity of working with you. To our Secretary, Woodford B. Troutman, M.D., and our Editor, Sam A. Overstreet, M.D., who give so generously of their time and counsel to us, we extend our special gratitude.

It is with deep regret that we said good-bye to William E. Rudd, our Executive Assistant, on September 1, 1961. He has served the Association well since December 1958. A substantial increase in income and opportunity dictated his reason for leaving the Association to go back to his hometown of Madisonville and re-enter the mining and construction business. Our best wishes go with him.

At the time this report is being written, we are not able to introduce Mr. Rudd's successor. We hope to be able to have you meet our new Executive Assistant at the House of Delegates first meeting.

We have a loyal, efficient and dedicated staff in our KSMA headquarters Office. Once more, I want to pay a special tribute to these staff members and to express my sincere appreciation for their good work.

J. P. Sanford
Executive Secretary

Recommendations, Reference Committee No. 1

The Committee considered the report of the Executive Secretary and fully realize that it only touches on the tremendous amount of work accomplished through his office. The Committee recommends acceptance of this report and wishes to express its sincere thanks for his efforts.

Mr. Speaker, I move the adoption of this section of the report. Motion was seconded and carried.

Resolution F

Muhlenburg County Medical Society

WHEREAS, the public has generously entrusted to medicine the duty of maintaining order in its own house; and

WHEREAS, a select committee of the American Medical Association, in an exhaustive survey, found defects in our housekeeping, and recommended measures for their correction; and

WHEREAS, the American Medical Association has adopted specific policies for the improvement of medical discipline; therefore be it

RESOLVED, that the Kentucky State Medical Association approve and concur in the recommendations of the American Medical Association, for the improvement of medical discipline, and

RESOLVED, that the officers of this Association diligently implement these policies.

Recommendations, Reference Committee No. 1

The next item considered by the Reference Committee No. 1 pertained to Resolution F introduced by the delegate from Muhlenburg County and concerning Medical Discipline.

Mr. Speaker, I move the adoption of this section of the report. Motion was seconded and carried.

Resolution I

Laurel County Medical Society

WHEREAS, there is among the medical profession a small number of physicans whose inept, unscrupulous, and unethical practice has brought dis-repute upon the entire medical profession and since such practices are as offensive to the vast majority of the medical profession as they are to the general public; and

WHEREAS, the only means organized medicine possesses to express its disapproval of such practices is removal of the offenders from the medical society and in view of the fact that such expulsions and the present laws have proven ineffective in preventing such abuses; and

WHEREAS, the general public is unaware that the medical profession has no legal means of eliminating such offenders and places responsibility upon the medical profession for protecting the general public from such practitioners; and

WHEREAS, the medical profession in several states has successfully demonstrated that physicians are not only desirous, but capable of policing their own profession if given legal means of doing so; and

WHEREAS, the Kentucky State Medical Association also disapproves of such practices and would accept responsibility for punishing such offenders if legal means were available,

BE IT THEREFORE RESOLVED, that the House of Delegates of the KSMA instruct its President to appoint a special committee, or advise the present Legislative Committee to draw up recommendations for the legislature of the Commonwealth of Kentucky to enact laws, creating a judical body within the medical profession of Kentucky with powers to subpoena, hear testimony, judge inept medical practices, as well as unethical conduct, and be able to invoke disciplinary action such as fines, suspensions, or revoke licenses; that such a body be elected by secret ballot of each licensed physician practicing in Kentucky and that those serving on such a body possess immunity under the law from civil action resulting from such decisions; and

BE IT FURTHER RESOLVED, that such a committee study the plan of the State of Washington as well as other states who have successfully implemented such a procedure and that such recommendations be presented to the next annual meeting of the House of Delegates for their approval before presentation to the state Legislature.

Recommendations, Reference Committee No. 1

The next item considered by the Reference Committee No. 1 was Resolution I introduced by the Laurel County Medical Society also pertaining to Medical Discipline.

Recommendations:

We approve this resolution in principle and further recommend that a special committee be approved to vigorously study this matter and present any further legislative recommendations to the 1962 House of Delegates.

Mr. Speaker, I move the adoption of this section of the report. Motion was seconded and carried.

Resolution J

Jefferson County Medical Society

WHEREAS, on two occasions over the past three years the annual meeting of the Kentucky State Medical Association has taken place during Yom Kippur which is the most sacred holiday observed by the Jewish faith and,

WHEREAS, we all realize that this conflict is happenstance rather than a planned occurrence, yet it has prevented some seventy members of the Jefferson County Medical Society from attending the meeting and,

WHEREAS, we should not only consider the increased attendance and contribution to be made of the absent members, but should also consider their personal feelings and,

WHEREAS, we realize that it is nearly impossible to plan a suitable date for everyone and perhaps, advanced plans make a change of date for the next meeting difficult, yet we feel this is important enough to warrant the Delegates' attention;

THEREFORE, BE IT RESOLVED, that the Delegates to the Kentucky State Medical Association instruct the Board of Trustees to change the date of the Association's Annual Meeting so that in the future, it does not conflict with the sacred Jewish holiday, Yom Kippur, or any other religious holiday if possible.

Recommendations, Reference Committee No. 1

The next item considered by the Reference Committee No. 1 was Resolution J which pertained to the Annual Meeting dates.

Recommendations:

It is recommended that further study of this matter be made by the Board of Trustees.

Mr. Speaker, I move the adoption of this section of the report. Motion was seconded and carried.

Mr. Speaker, I move the adoption of this report as a whole. Motion seconded and carried.

Reference Committee No. 1
Bruce Hamilton, M.D., Shepherdsville, Chairman
J. M. Bush, M.D., Mt. Sterling
Robert J. Hoffman, M.D., South Fort Mitchell
Henry Spalding, M.D., Bardstown
J. C. Woodall, M.D., Trenton

REFERENCE COMMITTEE NO. 2

Harold Eskind, M.D., Chairman
Reports on Scientific Assembly and Medical Education

Report of the Council on Scientific Assembly

PREFACE

Chapter VII, Section 4, of the KSMA Bylaws as revised in 1960, relating to the reorganization of the committee structure, reads in part:

". . . Each standing committee and Council shall report annually, at least six weeks prior to the Annual Meeting, to the House of Delegates via the Board of Trustees, respecting its activities during the year last past. These reports shall be transmitted without alteration or amendment, to the House of Delegates by the Board of Trustees at the Annual Meeting, with such comments or recommendations as the Board cares to make. . ."

The material in this report of the Council on Scientific Assembly is presented in the following order:

1. Actions and recommendations by the Council which it undertook on its own initiative.
2. Reports of the committees of this Council with the Council recommendations following each committee report.
3. Recommendations by the KSMA Board of Trustees on the over-all contents at the conclusion of the report.

The Council on Scientific Assembly held two meetings during the year. The first meeting was held November 10, 1960 and the second on July 13, 1961.

At the first meeting, careful consideration was given to the format for the 1960-61 Annual Meeting and the procedures were approved. It was noted that it was not possible to arrange for color television at this meeting because of conflicts.

At the second meeting, the scientific program for the 1961 session presented by the program committee was approved. Note was taken that the Board of Trustees had authorized the inclusion of a fourteenth specialty group—the Kentucky Industrial Medical Association—among those who cooperate in the presentation of our annual session.

We would like to call to the attention of all members that Edward R. Annis, M.D., Miami, Florida, will be in Louisville during our Annual Meeting and will speak to the Downtown Rotary Club on Thursday noon, September 21 and again that evening to a lay audience in the Flag Room of the Kentucky Hotel.

Considered by many to be one of medicine's greatest speakers against federal intervention in medical care, Doctor Annis is appearing in Louisville through the sponsorship of the Jefferson County Medical Society in cooperation with the KSMA.

For the first time, this year's meeting will present a scientific session on athletic injuries, their prevention and treatment. This new feature is being held as a result of a request of the AMA in asking Kentucky to serve as a "pilot" area in certain plans of athletic medicine.

It is felt by the Council that this is somewhat of an honor to have the opportunity to serve as a "spring board" or testing area for programs that could later be developed in other state associations. We, as physicians do have a definite responsibility in athletic medicine and we encourage those interested to hear this timely discussion on Tuesday afternoon, September 19. AAGP Category I credit will be allowed for this session.

Program Committee—Frank Gaines, M.D., Louisville, Chairman

Following the same format as in the past several years, your program committee has strived to again bring the best to KSMA members in the scientific speakers. As usual, there will be two half day sessions for the various specialty groups and in addition, each specialty group speaker will present a paper before one of the general sessions.

Much time has been devoted by the committee in discussing with representatives of the Kentucky Academy of General Practice the matter of qualifying the general sessions of the Annual Meeting for AAGP Category I credit. In order to qualify according to AAGP specifications, the programs must be "co-planned and co-sponsored" by an AAGP representative. At our April 26, 1961 meeting, a KAGP representative was present and participated in the planning of the scientific program, thus fulfilling the requirement.

It is the recommendation of the program committee that all general sessions of the Annual Meeting and the session on general practice be headed on the program as "co-planned and co-sponsored" by the KAGP.

Council Action: It is the recommendation of the Council on Scientific Assembly that the report of the program committee, along with the recommendation that the general sessions and the general practice session at the Annual Meeting be headed on the program as "co-planned and co-sponsored" by the KAGP

be accepted along with the other specialty groups.

Scientific Exhibits Committee, J. Thomas Giannini, M.D., Louisville, Chairman

There has not been a full scale committee meeting this year, but all members were contacted by phone concerning the exhibits.

All space in the scientific exhibit area has been alloted and at the time of allocation, one additional request was received, so actually only one prospective exhibitor has been turned down this year.

One innovation this year is the exhibit on Highway Safety which was prepared by the Kentucky State Police Department in conjunction with the KSMA Highway Safety Committee.

Council Action: It is recommended by the Council on Scientific Assembly and Arrangements that the report of the Scientific Exhibits Committee be accepted as presented by the chairman of the committee.

Technical Exhibits Committee, Donald K. Dudderar, M.D., Newport, Chairman

The committee on Technical Exhibits met in January at the Boone County Airport Building in a luncheon meeting. It reviewed the results of the 1960 Annual Meeting and noted that the confidential report of the Medical Exhibitors Association that was made following a survey of the exhibitors participating in the meeting was satisfactory.

The committee noted that there had been a ten per cent increase in rental charges of booth space for the 1960 meeting, and that the income from exhibits virtually paid for all expenses incident to the annual session.

Policies for the offering of space, development and promotion of attendance at the booths during the Annual Meeting were discussed and approved. Note was taken of the fact that a problem has developed in that a limited number of representatives of companies not exhibiting have in one way or another gained admission to the exhibit hall and are illegally soliciting business. Measures designed to discourage this practice were discussed and approved.

Your committee is glad to report that all 65 spaces for the 1961 Annual Meeting have been sold and that there is a substantial waiting list of companies wishing to purchase space.

Council Action: It is recommended by the Council on Scientific Assembly that the report of the Technical Exhibits be accepted as submitted by the chairman of that committee.

Awards Committee, William H. Bizot, M.D., Louisville, Chairman

While the KSMA Awards Committee traditionally reports at the first meeting of the House of Delegates its nominations for the KSMA Distinguished Service Medal and the Outstanding General Practitioner Award; and while it by authorization of the Board of Trustees reports at the President's Luncheon on its selection for the R. Haynes Barr Memorial Award, under the new system of committee reporting as called for by the bylaw change voted at the 1960 Annual Meeting, your committee wishes to report that it is working and will make its final report as indicated.

Council Action: This report was accepted for information by the Council.

Gold Committee, Edwin Solomon, M.D., Louisville, Chairman

The KSMA Golf Committee has not yet met but a meeting is scheduled at the Standard Country Club on July 14, 1961.

Barring any unusual circumstances, the tournament and the prizes will probably follow the same outline this year as the past.

This year's event will be held at the Standard Country Club and in addition to the traveling trophies, we will again offer other prizes to those participating.

We hope to make the out-of-town golfers feel at home and to enjoy this our phase of the Annual Meeting. There is presently $269.29 in the KSMGA Golf Fund which has increased over the past two-three years even though additional prizes have also been added.

Council Action: It is recommended by the Council on Scientific Assembly that the report of the Golf Committee be accepted as submitted by the chairman of that committee.

Council on Scientific Assembly
Gaithel L. Simpson, M.D., Greenville
Donald K. Dudderar, M.D., Newport
Frank M. Gaines, M.D., Louisville
J. Thomas Giannini, M.D., Louisville
Edmund D. Pellegrino, M.D., Lexington
Beverly T. Towery, M.D., Louisville
Richard G. Elliott, M.D., Lexington
Chairman

Recommendations of the KSMA Board of Trustees

The foregoing report is forwarded to the House of Delegates with the recommendation that the Council's report and the report of each of its committees be approved and implemented with the following exception:

On the recommendation of the program committee that all general sessions of the KSMA Annual Meeting and the session on general practice be captioned on the program as co-planned and co-sponsored by the KAGP, it was moved, seconded and carried that the program be published with the same headings as last year which would allow the KAGP Category I credit training.

Recommendations, Reference Committee No. 2

The reports of the Program Committee, Frank M. Gaines, M.D., chairman; Scientific Exhibits Committee, Thomas Giannini, M.D., chairman; Awards Committee, William H. Bizot, M.D., chairman and Golf Committee, Edwin P. Solomon, M.D., chairman, are approved and recommended for approval by the House of Delegates. This reference committee approves of Report #10 in its entirety as amended by the action of the Board of Trustees.

Mr. Speaker, I move the adoption of this report. Motion seconded and carried.

Report of the Council on Medical Education and Hospitals

PREFACE

Chapter VII, Section 4, of the KSMA Bylaws as revised in 1960, relating to the reorganization of the committee structure, reads in part:

". . . Each standing committee and Council shall report annually, at least six weeks prior to the Annual Meeting, to the House of Delegates via the Board of Trustees respecting its activities during the year last past. These reports shall be transmitted without alteration or amendment, to the House of Delegates by the Board of Trustees at the Annual Meeting, with such comments or recommendations as the Board cares to make . . ."

The material in this report of the Council on Medical Education and Hospitals is presented in the following order:

1. Actions and recommendations by the Council which it undertook on its own initiative.
2. Reports of the committees of this Council with the Council recommendations following each

committee report.

3. Recommendations by the KSMA Board of Trustees on the over-all contents at the conclusion of the report.

* * * * *

The Council on Medical Education and Hospitals has met two (2) times during this associational year to discuss the duties and functions of this Council. At each meeting there has been a full scale discussion on the activities of the committees serving under the Council. The AMEF Committee, the General Practice Committee, Hospital Committee, Postgraduate Medical Education and the two Advisory Committees to the University of Kentucky and Louisville Medical Schools.

At our last meeting we had as special guests Glen Laymaster, M.D., Chicago, with the AMA Council on Medical Education and Hospitals, and William R. Willard, M.D., Lexington, Dean of the U.K. Medical School. Doctor Willard is a member of the AMA Council on Medical Education and Hospitals. We feel that this proved to be fruitful and that we have established good relations with the AMA Council on Medical Education and Hospitals and that there is a need for better communications between the AMA Council and the State Councils. It is heartening to note that the AMA is in the process of strengthening its communications with the state societies and that it is definitely interested in being of more service to the states.

In this connection, we feel that Doctor Willard is to be commended for his interest in this matter and his desire in particular to see Kentucky come up with a leading pattern in this area. At a meeting in Chicago in February of Congress on Medical Education and Hospitals, it was discovered that Kentucky has an excellent program in the field of postgraduate opportunities as compared to several of the other states.

The reports of the committees covering their activity and recommendations are submitted below:

AMEF Committee—Robert McClendon, M.D., Louisville, Chairman

The last meeting of this committee was held during the 1960 Annual Meeting at which time a campaign was mapped in order to expand the program of the American Medical Education Foundation work in Kentucky.

We think it is interesting to note that $1,172,599.60 was contributed by physicians to AMEF during 1960 for distribution to 85 medical schools across the nation. Of this amount $9,327.32 has been distributed to the University of Louisville School of Medicine. At a later date the University of Kentucky School of Medicine will also be eligible for AMEF funds.

It is hoped by our committee that a satisfactory arrangement for securing funds for the AMEF program in Kentucky can be developed between the two (2) medical schools and the AMEF. At the present time there appears to be some conflict of interest in fund raising and it is hoped that a program can be developed which will utilize the experience and wisdom of all three groups.

Council Action: It is recommended by the Council on Medical Education and Hospitals that the report be accepted as above and that the Board of Trustees endorse the work of the committee in trying to get funds for a furtherance of medical education.

General Practice Committee—Homer Martin, M.D., Louisville, Chairman

The endeavors of the Committee on General Practice began where the 1960 group left off. Lack of general practitioners and the education of future general practitioners were agreed to be our greatest problems. The committee met in Louisville on May 11, 1961 and the conclusions reached at that meeting were presented by the chairman before the American Medical Association's Council on Medical Education and Hospitals in New York on June 27, 1961. It was at this meeting of the national group that the main recommendation of the 1960 KSMA General Practice Committee was formally adopted; viz., that surgery be an essential of general practice residency training programs.

The present report will consider the status of the general physician—nationally and locally. Aside from efforts to impose governmental medicine on the public, the decrease in the number of general practitioners constitutes the most crucial problem facing medicine today. This will require not only our thought but our best efforts as well if the whole structure of American medicine is to be retained.

The General Practitioner in the United States

Statistics of the AMA during 1961 (in the first such tabulation since 1949) show that the full-time specialist has outnumbered the general practitioner for the first time in history. Of 251,643 physicians in the United States, 56 per cent belong to the specialist ranks and 44 per cent to general practice.

The profession has seen a 64 per cent increase in full time specialists and a 38 per cent drop in part-time specialists, and a 6 per cent drop in the general practitioners. Greatest increases were in neurology —578 per cent, psychiatry—328 per cent, anesthesiology—297 per cent, neurosurgery—241 per cent, and pathology—193 per cent.

These figures mean to the general practitioner that the practice of 2,062 persons he was responsible for in 1949 has grown to 2,617 today and will become a projected 3,336 persons for each general practitioner by 1970.

The General Practitioner in Kentucky

Although the number of physicians has risen 25 per cent nationally in the past 40 years, the trend in Kentucky has been in the opposite direction—from 3,316 doctors in 1921 to 2,759 in 1961. On the basis of doctor per 100,000 population (which has remained constant at 135 in the United States), the 136 doctors per 100,000 we had in Kentucky in 1921 has fallen to 91 per 100,000 in 1961.

Only the leading urban centers may be said to have an adequate supply of doctors—Louisville and Lexington—and even these show a gradual loss. Louisville had 164 doctors /100,000 in 1940 and 137 in 1959. Comparable figures for Lexington would be 186 and 170. As a basis for comparison, Nashville has 191, Indianapolis 178 and 154 for Cincinnati.

As to the type of practice engaged in, definite trends are apparent in the actual figures:

Kentucky Doctors' Distribution		1949		1959
Private Practice				
Specialists	631		868	
General Practitioners	1,521		1,228	
Total in Private Practice		2,152		2,096
Hospital Service		203		344
Retired and/or not in practice		136		101
Federal Government		36		
Teaching				97
TOTALS		2,527		2,638

Thus, the trend is consistent in Kentucky though less steep: the numbers of specialists increased 25 per cent to 32 per cent while general practitioners decreased from 60 per cent to 46 per cent. Although 1 in 5 of Kentucky's General Practitioners were part time specialists in 1949, that percentage has probably fallen if the national trend prevails here.

Urban and Rural Differences in Physician Supply

The physician supply quite naturally increases with the population of an area. For each 100,000 population, there are 153 doctors on the average in greater

metropolitan areas, 125 in lesser metropolitan areas, 75 in areas adjacent to metropolitan areas, 80 in isolated semi-rural areas and 47 in isolated rural areas. The number of general practitioners /100,000 persons remains constant (between 45 and 50) for all areas so the variation is in the specialists and hospital personnel.

The general practitioner, therefore, is solidly represented in all geographic areas and the specialists and hospital personnel increases with population density. The internists and pediatricians who reciprocate with general practitioners in serving as family physicians in cities are not available to do so in the country.

Work Load of Physicians

The average daily work load of physicians (in a 1947 survey) was 10 hours. This is lowest in greater metropolitan areas (9.2 hours) and greatest in isolated rural areas (10.9 hours). In a year's time, this would make a tremendous difference between the city and country doctor, not only in increased work but also the lack of leisure and rest.

This suggests some of the reasons behind the difficulties in maintaining sufficient numbers of rural physicians. Such a work load not only overworks the rural physician but makes his continuing education a greater problem. This is one big reason for a man leaving an established practice: insufficient study hours and a feeling of inadequacy.

Still another factor in attracting a doctor to leave general practice is a comparison of incomes of 18,881 physicians in a 1949 survey. For all ages, the specialist had a mean net income of $15,014 annually to $8,835 for the general practitioner. Not only does the specialist enjoy a better income but the percentage becomes even greater in old age.

Candidates for General Practice—1960

According to Charles F. Schumacher for the Association of American Medical Colleges, this is what the 1960 medical graduates are planning for the future:

Entering General Practice	20%
Entering a Specialty	41%
Specialty plus Teaching and Research	36%

Graduates seeking internships are principally interested in the academic status of a hospital. The pay no longer influences the choice. The major teaching hospitals are by far the most successful in meeting internship quotas.

Previous Residency Programs

Residencies in General Practice today have met with fair acceptance. The drawback to this is that there aren't enough residencies available to produce significant results. Reasons for this lack of interest and growth are: to the student, he does not feel the training has a value equal to that which leads to board qualifications; to the school, the program is experimental and no staffs or budgets are provided; and, in actuality, the program is not general practice but is time divided between various specialties. The medical schools themselves share some blame as emphasis on specialization has made such attainment a status symbol.

Current Program Planning

Planners of residency programs at present are dividing the 24 month program, to begin in 1965 or thereabouts, into various combinations. The "open-end" program, designed to allow sufficient flexibility to train a specific individual for a specific community, is generally agreed upon. This was also recommended by this committee in earlier reports.

Regardless of how the 24 month period is divided, general practice will attract graduates when the training offered is qualitatively equal to other residency programs.

Present Postgraduate Programs

The Kentucky Academy of General Practice and Postgraduate Education Office of the Kentucky State Medical Association continue to offer programs of high quality in every segment of the state. Interest in these programs remains high. It is hoped that even greater variety will be offered as such training continues. This is work well done.

Conclusions

1. The current statistical surveys indicate a critical decrease in the number of practicing general practitioners requiring positive action if the structure of American Medicine is to be preserved.
2. The general practitioner is decreasing in numbers in Kentucky at the rate of two dozen per year on the average. This number would ordinarily care for 600 citizens per day or 150,000 patient visits per year.
3. Medical school graduates are migrating to major teaching hospitals for training and the private hospitals are losing out.
4. Present general practice programs are not impressive to possible candidates. It is believed the competition will become equal when the training becomes equal.
5. The Kentucky Academy of General Practice and the Postgraduate Education Office of the Kentucky State Medical Association are most active and programs sponsored by them amount to 170½ and 150 hours, respectively.

Recommendations

On the basis of its work this year, the Committee recommends that:

1. Next year's committee be instructed to take on the responsibility of collecting all information on the two year general practice training program, making it available to the medical schools of Kentucky and report next year on the progress locally. Through personal efforts we can expedite the local handling of a critical national problem.
2. Further study of the problems of the rural doctor be undertaken and ways of diminishing his work load sought while making his postgraduate study more available to him.
3. Further efforts to introduce medical students to rural practice for at least short periods by use of Hill-Burton Hospitals and other means.
4. Continued and even more cooperation between the two groups providing continued education for the general practitioner—the Kentucky Academy of General Practice and the Postgraduate Education Office of the Kentucky State Medical Association.
5. And, finally, if the funds can be arranged, survey the general practitioners of Kentucky in order to provide proper preparation in the state's schools of medicine.

It is the belief of this Committee that the possible extinction of General Practice should not be the concern of any single segment of the profession. Preservation of medical practice as it exists today as well as the health of the nation hinges on the available, well trained general physician. It is our belief that General Practice, when properly performed, is a specialty and as important as any other. In making these recommendations, the General Practice Committee feels we serve Medicine best when we serve our community best.

Council Action: The Council on Medical Education and Hospitals reviewed and accepted the report of

the Committee on General Practice. The Council wishes to thank this committee for the extensive work which the report represents. The Council recommends that work and studies of this committee be continued as requested in the above report.

Hospital Committee—James B. Holloway, M.D., Lexington, Chairman

This committee has met twice, once in February and again in June. At each meeting, representatives of the Kentucky Hospital Association were invited to attend and their suggestions were most helpful to the committee. Our meetings were well attended and the KSMA members were all most helpful with their suggestions.

At the first meeting we talked of generalized topics and wondered what we might do and asked our staff to get together some information for us which they did. At the second meeting we reviewed this information, particularly the status of the hospitals in Kentucky and the license and laws of the state. As you can see, we have recommended that a committee of the Kentucky Hospital Association and KSMA get together on going over in detail the licensing laws. We also feel that some effort must be made to help those hospitals in Kentucky that would like to become accredited by the Hospital Board, i.e. the American Hospital Association. Therefore, the committee is recommending that the committee of the KSMA and the Kentucky Hospital Association get together and set up the dry run system to aid those hospitals that might seek aid on their own.

There are about sixty hospitals in the state that are not accredited that should be or could be and we feel that this is the first step toward helping them. In the future years something else might be done to stimulate them along, but we thought that it was best to take it one step at a time. Lastly, we discussed at some length the privileged communications and the ownership of hospital charts. Here again, the committee felt that they should go along with the other committees working on this in the state and our recommendation is that something be put before the legislature.

The following recommendations are made:

(1) A committee composed of both KSMA and KHA members to give further study to the licensing laws in Kentucky for hospitals and see how they compare with other states and further see if they should be strengthened beyond their present form.
(2) A committee be set up composed of members of the KSMA and KHA which will assist those hospitals that would like to become better prepared to meet creditation requirements. Assistance to be given in the form of a "dry-run" much after the fashion of the Texas plan.
(3) Privileged Communications. The Hospital Committee recommends that the Council back the other councils and committees in their thinking regarding privileged communications and we recommend that the Council recommend that legislation be introduced in the 1962 General Assembly which would define the ownership of the hospital chart, what constitutes the hospital chart and what portion of information on the chart should be released to the insurance companies and the press. They further recommend that any legislation along these lines should be done with the approval and cooperation of the Kentucky Hospital Association.

Council Action: The above recommendations of the Hospital Committee have been reviewed by the Council on Medical Education and Hospitals. Referring to recommendations (1) and (2), the Council recommends that no new committees be formed but rather that the present Hospital Committee be given the authority to proceed with these two projects.

Referring to Recommendation (3), the Council is aware that many Kentucky physicians are interested in this matter but the Council also understands that there is information available which would indicate that this matter should receive additional and careful study before any attempt at legislation is made.

Postgraduate Medical Education Committee—Walter S. Coe, M.D., Louisville, Chairman

Since the submittal of last year's report, the following activities have been conducted by the Postgraduate Medical Education Office, 104 West Chestnut Street, Louisville 2, Kentucky.

1. PAST AND PRESENT POSTGRADUATE MEDICAL OPPORTUNITIES
   A. In Bowling Green there was a Postgraduate Course on CHRONIC DISEASE, held on October 19 and 20, 1960, at the Ole Fort Restaurant. (See attachment #1)
   B. In Louisville there was a Postgraduate Course on OBSTETRICS & GYNECOLOGY, which was held on November 9 and 10, 1960, at the Kentucky Hotel. (See attachment #2)
   C. In Louisville again there was a Postgraduate Course on ELECTROCARDIOGRAPHY, held at the Louisville General Hospital every Wednesday evening from 7 until 9 p.m., January 11 through March 15, 1961. A 68-page syllabus was prepared as a text for this course by this office. *((See attachments #3 and #4)
   D. In Louisville at the Louisville General Hospital there is a permanent-type Postgraduate Course in OBSTETRICS & GYNECOLOGY being held every week during 1961, and continuing for 1 full week in duration. This course includes: clinics, lectures, grand rounds, pathology, operations, manikin demonstrations, and rotating night duty. *(See attachment #5)
   E. In Louisville at Children's Hospital, there was a Postgraduate Course on PEDIATRICS, which was held every Tuesday morning from 9:30 until 12:30. This course was held from April 4, 1961 until May 23, 1961. The course included Ward Rounds, Cases Conferences, and Scientific Presentations. *(See attachment #6)
   F. In Lexington, at the new University of Kentucky Medical Center, a Postgraduate Course on HEMATOLOGY was held on April 19 and 20, 1961. There were four out-of-state speakers—Mayo Clinic in Rochester, Minnesota; Cleveland Clinic in Cleveland; National Institutes of Health in Bethesda, Maryland; and the University of Cincinnati Medical School in Cincinnati. This course utilized panel discussions, question and answer periods, scientific presentations, and a Clinical-Pathological Conference. (See Attachment #7)
   G. In Louisville on May 9, there was a symposium on ALCOHOLISM which was held at the Brown Hotel from 6:15 until 10:00. After the dinner, there was an open question and answer period, immediately following the scientific papers.

** These courses are extensions of the standard Postgraduate Courses, in that the hospital facilities are utilized in the hospital rounds and clinics. It is our aim to further this type of program, thus insuring a better and more thorough presentation of the main topic of the course.*

II. FUTURE PROGRAMS (At the time this report was prepared)

A. There will be a Postgraduate Course on PEDIATRICS on June 8, 1961, at Gabe's Restaurant in Owensboro, Kentucky. There are frequent question and answer periods throughout the program, in order to provide a more complete understanding of the material presented. (See attachment #8)

B. On July 13, 1961, there will be a Postgraduate Course on GENERAL MEDICINE at Harrodsburg, at the Beaumont Inn, with question and answer periods. (See attachment #10)

C. In Paducah, Kentucky on October 5, 1961, there will be a Postgraduate Course on OBSTETRICS. This will be a one day meeting, and like the above, with discussion periods.

D. A Postgraduate Course on X-RAY INTERPRETATION will be offered in Louisville at the Louisville General Hospital. This will be an intermittent program, being held on every Thursday from October 5 until December 21, 1961.

E. In Louisville on October 26, there will be a Postgraduate Course on ANESTHESIOLOGY. This course will be held in Louisville General Hospital.

F. On October 19, another Postgraduate Course will be offered, this being on RECENT ADVANCES IN THERAPEUTICS in Pikeville.

G. In Louisville on November 16, there will be a Postgraduate Course on the subject of CLINICAL NEUROLOGY. This meeting will be held in Louisville General Hospital.

H. Date to be determined, CHEST DISEASES, Lexington. (See attachment #10A)

III. PENDING COURSES

A. There is a proposed two year fellowship in pelvic surgery to be originated at Norton's Infirmary in Louisville, under the sponsorship of the Department of Obstetrics and Gynecology, Douglas M. Haynes, M.D., Professor and Chairman of the Department, and Laman A. Gray, M.D., Associate Professor of Obstetrics & Gynecology and Associate in Pathology. This course is also under the sponsorship of the University of Louisville Medical School and the Postgraduate Medical Education Office. This course has been submitted for a federal grant in Washington. It will enroll two Board Certified physicians the first year, and one each following year. (See attachment #11)

B. In Lexington at the University of Kentucky Medical Center, there is a pending Postgraduate Course for spring 1962 to be on the subject of PSYCHIATRY.

IV. TRUSTEE DISTRICT MEETINGS

As last year, scientific speakers were secured by this office for the following Trustee District Meetings:

A. The 14th District meeting, which was held on April 19, in Paintsville had three speakers, one of which was sponsored by Merck Sharp & Dohme. (See attachment #12)

B. The 11th District meeting which was held on April 27, in Richmond, Kentucky, had one speaker who was sponsored by Merck Sharp & Dohme. (See attachment #13)

C. The 1st District meeting had one speaker. This speaker was sponsored by Merck Sharp & Dohme, and spoke on May 25 at Kenlake. (See attachment #14)

D. At the 2nd and 3rd Districts' meeting in Henderson on May 26, there were two speakers, both on the staff of the University of Louisville. (See attachment #15)

E. The 12th and 15th Districts' meeting on June 1, had three speakers, one of whom was sponsored by Merck Sharp & Dohme. This meeting was held at Cumberland Falls. (See attachment #16)

F. On June 8, the 7th District will have a meeting at Frankfort. At this meeting there will be three speakers, all of whom have staff status at the University of Louisville Medical School. (See attachmest #17)

G. The 4th and 6th Districts' meeting, which will be held on June 22 at the State T.B. Hospital in Glasgow, will have three speakers. Again, one of these will be sponsored by Merck Sharp & Dohme. (See attachment #18)

V. PROMOTIONAL ACTIVITIES

A. As usual form letters were sent out to various persons and institutions asking for their cooperation in our activities as Clearing House for speakers; topics and locations of Postgraduate opportunities. The response became increasingly better during the last six months. There are 135 persons and organizations on our special mailing list. (See attachment #19)

B. In addition to the publication of Postgraduate listings in the KSMA Journal, our courses will now also be published on a national basis through the POSTGRADUATE MEDICINE Magazine published by the Interstate Postgraduate Medicine Association at Minneapolis, Minnesota. The Jefferson County Medical Society BULLETIN, and the Kentucky Academy of General Practice magazine, the GP, also now carry our listings.

C. Again this year questionnaires from the American Medical Association's Council on Medical Education and Hospitals were submitted for publication in their POSTGRADUATE COURSES FOR PHYSICIANS Publication. Due to the limitation in our future plannings, only 11 programs for this year and early 1962 will be published, whereas listings until August, 1962 could be submitted. An increase in Postgraduate activities can be noted by comparing the publications of the AMA from 1958 until the present time. According to their listings of 1958-1959, and 1959-1960, only one postgraduate course was held in the State of Kentucky. After the establishment of the Postgraduate Medical Education Office, the publication of 1960-1961 showed an increase to 5 courses, and the 1961-1962 edition will show 11 courses—over a 100% increase, which means that according to these AMA listings Kentucky will rank well above the average state in Postgraduate Medicine in the country. (See attachment #20)

D. Additional promotional work was conducted by having a little exhibition booth at the Annual KSMA Meeting—September 20-22, where we had a special brochure distributed. (See attachment #21)

E. Since the establishment of this office, approximately 25,000 pieces of mail have been sent out, thus indicating our promotional efforts and activities.

VI. FINANCIAL REPORT

A. The quarterly statements were submitted regularly to the Chairman of the Postgraduate Committee, W. S. Coe, M.D.

B. More funds will be necessary if the future activities of this office are to be increased to where this office will be recognized nationwide and our programs will contain even better and more qualified speakers, and the

facilities can be obtained to insure even better attendance and more thorough coverage of the subject presented.

C. The only additional income to that of the KSMA Fund appropriation came from the Kentucky State Department of Health in Frankfort, from which we received $400 each for our Postgraduate Course on CHRONIC DISEASE, and our Postgraduate Course on OBSTETRICS & GYNECOLOGY, and $420 in fees from the course on ELECTROCARDIOGRAPHY. It should be pointed out that in order to increase the range and scope and also to underwrite Postgraduate activities in the future, fees will have to be charged at all meetings in order to cover our promotional costs plus occasional honorariums and expenses for speakers.

VII. MISCELLANEOUS FEATURES

A. The Tax Exempt application for this office is under consideration by the Department of Internal Revenue in Washington at the present time. The approval depends on further information requested by them on our organizational and operational status which information is being furnished by Mr. Gaines Davis, attorney at law for the KSMA and the Postgraduate Medical Education Office.

B. Attendance at Postgraduate Courses has produced an over-all average of 55 physicians per course. There has been a total of 387 physicians attending our programs since they were first offered. The average attendance at our postgraduate courses with the exception of the Symposium on Alcoholism is 27.

C. The response and cooperation from the various institutions that receive our form letters has become increasingly better.

D. Of the courses which have been offered, we have received 108 hours of Category I credit from the Kentucky Academy of General Practice, in 123 hours of instruction.

NOTE: All attachments as noted in this report are on file at the KSMA Headquarters Office. They are not enclosed inasmuch as they would cover some additional 100 pages.

Council Action: The above report has been reviewed by the Council on Medical Education and Hospitals. The Council considers the above report to be a fair and accurate account of the activities of the Postgraduate Medical Education Committee during the past year. The Council recommends that the KSMA continue and extend its support and interest in the field of Postgraduate Medical Education.

Advisory Committee To The U.K.—O. Leon Higdon, M.D., Paducah, Chairman

This committee met during the last State Medical Society meeting in Louisville in September, 1960. At that time Doctor William R. Willard reported further on the progress at the Medical Center of the University of Kentucky, discussing briefly:

1. Appointments of present staff members and prospects for additional faculty and staff members.
2. Policies followed in selection of the first class of forty Freshmen students at the Medical School and plans for future enrollments.

In May, 1961, Doctor Willard attended a Career Day Program at the Paducah Tilghman High School, which was attended by approximately 150 Senior High School students from various schools in the First Congressional district. This program was geared to furnish information to prospective medical students and the allied professions. These students were enthusiastic and many interesting discussions resulted.

On May 18, at a meeting of the Council on Medical Education and Hospitals, the University of Kentucky progress was further discussed and this has been reported on a resumé of that meeting, Briefly, pertinent subjects discussed were relationships of the Medical Center.

a. To state wide graduate training.
b. Once the University of Kentucky Medical Center is accredited, some plans by which participation in the AMEF program.
c. Discussion of future meetings between the University of Kentucky-University of Louisville Advisory Committees regarding a common program.
d. Further discussion of policies relative to acceptance of and planning for an increase in the number of students in the 1961-62 Freshman class.
e. The role of the University of Kentucky in training of physicians for rural areas.
f. Discussion of time for next meeting, possibly to be held during the next State Medical Meeting in Louisville in September, 1961.

Council Action: The above report has been reviewed by the Council on Medical Education and Hospitals. In addition to the above, the Council recommends that the Advisory Committee to the University of Kentucky and University of Louisville have two meetings a year and that one of these two meetings be a joint meeting.

In connection with the above report, the Council wishes to urge the trustees, delegates and members of KSMA to continue and extend their interest in medical education in Kentucky. The financial support of medical education and legislation relating to medical education are two specific areas in which the KSMA should continue active interest and participation.

Advisory Committee to the U.L.—Hollis Johnson, M.D., Louisville, Chairman

This committee has not met during the year and the present chairman was not appointed until January 26, 1961, inasmuch as the original chairman had resigned this position. There have been no matters referred to this committee.

Council Action: It is recommended by the Council on Medical Education and Hospitals that the above report be accepted.

As chairman of the Council, I would like to express my appreciation to the members of the Council who have worked on this year's activities. Additionally, I would like to commend the various committees for their interest and work in committee affairs during the associational year.

Council on Medical Education and Hospitals
Hollis Johnson, M.D., Louisville
O. Leon Higdon, M.D., Paducah
J. B. Holloway, M.D., Lexington
Robert McClendon, M.D., Louisville
Homer Martin, M.D., Louisville
Walter S. Coe, M.D., Louisville, Chairman

Recommendations by the KSMA Board of Trustees

The foregoing report is forwarded to the House of Delegates with the recommendation that the Council's report and the report of each of its committees be approved and implemented with the following exception:

The Board concurs in the Council's disapproval of the recommendation that committees be formed to (1) give further study to the licensing laws in Kentucky for hospitals and (2) assist those hospitals that would like to become better prepared to meet creditation requirements. The Board also concurs in the Council's recommendation that the privileged communications matter should receive additional study before any attempt at legislation is made.

Recommendations, Reference Committee No. 2

Report No. 11 deals with the following committee reports: AMEF Committee, Robert McClendon, M.D., chairman; General Practice Committee, Homer Martin, M.D., chairman; Postgraduate Medical Education Committee, Walter S. Coe, M.D., chairman; Hospital Committee, James B. Holloway, M.D., chairman; Advisory Committee to the U. of K., O. Leon Higdon, M.D., chairman; Advisory Committee to the U. of L., Hollis Johnson, M.D., chairman.

Report of the AMEF Committee

We approve this report, but certainly hope that there will be a resolution on the conflict of interest and fund raising.

Mr. Speaker, I move the adoption of this section of the report. Motion seconded and carried.

General Practice Committee

On the report of the General Practice Committee, we wish to add to the last sentence in the first paragraph of this report, the words "and obstetrics." The sentence will then read as follows: "It was at this meeting of the national group that the main recommendation of the 1960 KSMA General Practice Committee was formally adopted; viz., that surgery *and obstetrics* be essentials of general practice residency training programs."

We wish to compliment Doctor Homer Martin for his excellent and extensive work on this committee.

Mr. Speaker, I move the adoption and implementation of this section of the report. Motion was seconded and carried.

Hospital Committee

The next section of this report has to do with the Hospital Committee. We considered this report with the exception of the portion dealing with privilege communications (section three, page eight) which was referred to Reference Committee No. 3. The report is approved and recommended to the House of Delegates.

Mr. Speaker, I move the adoption of this section of the report. Motion was seconded and carried.

Postgraduate Medical Education Committee

The next section of the report has to do with the Postgraduate Medical Education Committee. This section of the report is approved and recommended to the House of Delegates.

Mr. Speaker, I move the adoption of this section of the report. Motion was seconded and carried.

Advisory Committee to the U. of K.

This section of the report is recommended to the House of Delegates for approval and the recommendations of the Board of Trustees in reference to forming a new committee.

Mr. Speaker, I move the adoption of this section of the report. Motion seconded and carried.

Advisory Committee to the U. of L.

This section of the report is recommended to the House of Delegates for approval.

Mr. Speaker, I move the adoption of this section of the report. Motion seconded and carried.

Mr. Speaker, I move the adoption of Report No. 11 in its entirety, as amended by the recommendations of the KSMA Board of Trustees. Motion seconded and carried.

Resolution B

TO: The Board of Trustees of the Kentucky State Medical Association
FROM: Robert C. Long, M.D., Delegate to the American Medical Association
Subject: The KSMA Policy concerning Osteopathic Medicine

Whereas, In most sessions of the AMA House of Delegates for the last one-third of a century the question of relationship between physicians and osteopaths has been studied and discussed and in 1960, at the request of the Board of Trustees of the AMA, the Judicial Council studied all facets of the osteopathic question, and

Whereas, In 1961, the Judical Council, supported by resolutions from three different states, relating to this issue, presented its report to the House of Delegates from which the attached statement of policy of the AMA was formulated (See attached statement of the Reference Committee on Amendments to the Constitution and By Laws), and

Whereas, The House of Delegates of the AMA has unanimously adopted this policy,

THEREFORE BE IT RESOLVED that the Board of Trustees recommend to the House of Delegates of the Kentucky State Medical Association that they adopt for implementation the policy and recommendations of the AMA.

Board of Trustees Action, 9-18-61

Doctor Norvell moved and Doctor Coleman seconded that the Jefferson County resolution be accepted by the Board of Trustees and presented to the House of Delegates with recommendations for its adoption. The motion carried.

Report of Reference Committee on Amendments to the Constitution and Bylaws AMA Meeting, June, 1961

1. There can never be an ethical relationship between a doctor of medicine and a cultist, that is, one who does not practice a system of healing founded on a scientific basis.
2. There can never be a majority party and a minority party in any science. There cannot be two distinct sciences of medicine or two different, yet equally valid, systems of medical practice.
3. Recognition should be given to the transition presently occurring in osteopathy, which is evidence of an attempt by a significant number of those practicing osteopathic medicine to give their patients scientific medical care. This transition should be encouraged so that the evolutionary process can be expedited.
4. It is appropriate for the American Medical Association to *reappraise its application of policy* regarding relationships with doctors of osteopathy in view of the transition of osteopathy into osteopathic medicine, in view of the fact that the colleges of osteopathy have modeled their curricula after medical schools, in view of the almost complete lack of osteopathic literature and the reliance of osteopaths on and use of medical literature and in view of the fact that many doctors of osteopathy are no longer practicing osteopathy.
5. Policy should now be applied individually at state level according to the facts as they exist. Heretofore, this policy has been applied collectively at national level. The test now should be: Does the individual doctor of osteopathy practice osteopathy, or does he in fact practice a method of healing founded on a scientific basis? If he practices osteopathy, he practices a cult system of healing and all voluntary professional associations with him are unethical. If he bases his practice on the same scientific principles as those adhered to by members of the American Medical Association, voluntary professional relationships with him should not be deemed unethical.

There are several methods to evaluate the professional, ethical, and scientific competence of practitioners of medicine. The constituent medical associations shall

use the same criteria to evaluate the professional, ethical, and scientific competence of those practicing osteopathic medicine. It might be helpful in addition, to evaluate the professional and scientific competence of a doctor of osteopathy according to his professional education and the type of examination given and the license granted to him by the state in which he practices. It might be possible to establish these standards through the development of state liaison committees of doctors of medicine and doctors of osteopathy. In some states it might be possible to initiate and complete negotiations for the elevation of osteopathic schools to educational equivalence of medical schools according to the standards of the Council on Medical Education and Hospitals. In view of the above recommendations which include the spirit and intent of resolutions 33, 60, and 88, your reference committee believes that action need not be taken on those resolutions.

Mr. Speaker, I move the adoption of this portion of the report.

Recommendations, Reference Committee No. 2

Resolution B—KSMA policy concerning osteopathic medicine. This resolution was carefully considered and discussed. Since many of this group of men (osteopaths) have comparable training and since they would be considered on an individual basis for membership in the society and hospital staff, we recommend the adoption and implementation of this resolution.

Mr. Speaker, I move the adoption of this section of the report. Motion seconded and carried.

Resolution C

Campbell-Kenton County Medical Society

1. Recommend that efforts to place foreign medical graduates under the intern matching program be unalterably opposed.
2. That the E.C.F.M.G. examination be used as a guide, either by local hospitals or county or state organizations, in evaluation of prospective interns or residents; and that accreditation of the hospital not be influenced by acceptance E.C.F.M.G. examination.
3. That efforts be continued to make the E.C.F.M.G. examinations more fair and more objective.

Recommendations, Reference Committee No. 2

Resolution C—the American Medical Association's ECFMG Program. Section One of this resolution was upheld. Section Two was opposed. Section Three: Since the committee heard conflicting reports of this section of the resolution, it was felt that this matter deserves further study. The reference committee feels that the examination should certainly be fair but the test must be a comprehensive one.

Mr. Speaker, I move the adoption of this section of the report.

Minority Report—Resolution C

I wish to submit a minority report regarding Resolution C which was submitted by the Campbell-Kenton Medical Society on the subject of the American Medical Association's ECFMG Program.

Under Part One, whereas the majority opinion was to uphold this section of the resolution, I wish to oppose it. I believe it will be to the advantage of the public and to medicine for a competent foreign graduate to have every advantage of the best training program that we may offer him. In this way he may better serve his community on a higher level of skill.

I believe that the examination should be fair, comprehensive and comparable to examinations submitted to our own medical graduates. And, if these men are competent, they should be given advantage.

Harold Eskind, M.D.

Following reading of both majority and minority reports on Resolution C, a discussion ensued. The following compromise motion was then offered, covering both the majority and minority reports: "It is the intent of the House of Delegates that the KSMA opposes the forcing of foreign medical graduates into the matching internship program of the ECFMG. Motion was seconded and carried.

Resolution D

Campbell-Kenton County Medical Society

WHEREAS, private hospitals have recently experienced much difficulty filling their intern quotas, and

WHEREAS, the training interns receive in private hospitals affords an understanding of private practice superior to that of teaching centers, and

WHEREAS, this experience can be an important factor in molding a good specialist as well as forming good ground work for a generalist and,

WHEREAS, completing intern quotas of private hospitals would serve to improve total patient care, and

WHEREAS, interning in a private hospital may encourage additional physicians to practice general medicine, thereby helping to fill a serious gap in medical service, and

WHEREAS, the great bulk of interns now go to teaching centers,

Therefore be it Resolved, that the Kentucky State Medical Association recommend to the American Medical Association that those hospitals having a significant residency program, either eliminate their internship program or reduce it to the minimum compatible with good patient care.

Recommendations, Reference Committee No. 2

Resolution D—interning program. Mr. Speaker, the reference committee moves the adoption and implementation of this resolution as a whole. Motion seconded and carried.

Mr. Speaker, I move the adoption of this report, as amended, as a whole. Motion seconded and carried.

Reference Committee No. 2
Harold Eskind, Louisville, Chairman
Thomas McElhinney, Covington
Thurman Perry, Jenkins
J. S. Williams, Nicholasville

REFERENCE COMMITTEE NO. 3

F. R. Scroggin, M.D., Chairman
Reports on Legislative Activities

Report of the Council on Legislative Activities

PREFACE

Chapter VII, Section 4, of the KSMA Bylaws as revised in 1960, relating to the reorganization of the committee structure, reads in part:

". . . Each standing committee and Council shall report annually at least six weeks prior to the Annual Meeting, to the House of Delegates via the Board of Trustees respecting its activities during the year last past. These reports shall be transmitted without alteration or amendment, to the House of Delegates by the Board of Trustees at the Annual Meeting, with such comments or recommendations as the Board cares to make . . ."

The material in this report of the Council on Legislative Activities is presented in the following order:

1. Actions and recommendations by the Council which it undertook on its own initiative.

2. Recommendations by the KSMA Board of Trustees on the overall contents at the conclusion of the section on National Affairs and also at the end of the section on State Affairs.

Part I—National Affairs

The acting chairman of the Council on Legislative Activities on the National Level was appointed because of the illness of the regular chairman in April, 1961. The groundwork had been solidly laid and efforts were continued on the basis of existing policy. The privilege of continuing this important work has been a challenge and a source of personal gratification.

THE MAJOR EFFORTS OF THE COUNCIL on this level in this short time have been directed toward the furtherance of the practice of medicine as a private enterprise in the manner we have proven to be non-excelled, with the added protection offered the indigent aged through the Kerr-Mills Bill, versus the avowed forces of socialism, which we feel are determined to socialize the entire economy of our country through the pretense that 16,000,000 aged are unable to provide for their own medical care.

It has become clear that the vehicle of Social Security, once the philosophy of providing services instead of funds has been established, can and will spill over into other areas whereby Social Security can dominate our Federal elections and our government.

At this point another critical period is felt to have been weathered because of the announcement of Speaker Rayburn to the effect that no House action would be taken on the King Bill HR 4222 this year because of insufficient votes to get the bill out of the House Ways and Means Committee. This is the bill that would put care for the aged under Social Security.

The apparent strategy is to make this a major issue in the next congressional campaign and to make the race intolerable for those candidates who are not outspokenly in favor of this bill during the campaign.

Two decisive factors to our advantage are believed to be:

(1) The authorship of the Kerr Mills Bill by Congressman Wilburn Mills, the Chairman of the House Ways and Means Committee and

(2) The presence on the Committee of strong conservative congressmen who do not wish to see medicine socialized.

The atmosphere in Washington may have been influenced a little toward the side of medicine in the past year by medicine's determined stand and the effectiveness of medicine's recent past aggressive pronouncements on television, in newspapers and numerous other media in which they have presented their position clearly and honestly.

The position of medicine has greatly improved in the past year and has brought forth cries of "The most powerful and best financed lobby in Washington" from some antagonistic senators and labor leaders. Our sincerity and dedication has not been unnoticed and has brought us some powerful allies whose ideas concerning free enterprise are similar to ours.

The successful implementation of the Kerr-Mills law by over one fourth of the states, and its impending enactment by a number of other states has been a factor of major importance in influencing congressmen from these states to wait and see what the outcome of this will be.

MEDICINE ON THE NATIONAL LEVEL HAS ASSUMED OBLIGATIONS IN INFLUENCING LEGISLATION in many areas besides the King-Anderson and the Kerr-Mills bills. The major issues in which medicine has a definite interest are:

(1) For H.R. 7756: A bill to amend the internal revenue code to ease the burden of medical, hospital, and drug costs on persons over 65 and their dependents. Introduced by Congressman Durward Hall of Missouri on June 20, 1961. Congressman Hall said that this measure, along with the Kerr-Mills law, will go a long way toward enabling our senior citizens and families to meet their own responsibilities without relying on the Federal Government to take care of them.

(2) H.R. 10: A measure designed to encourage voluntary pension plans for the self employed. Was reported out of the House Ways and Means Committee on June 5, 1961 and is now before the Senate Finance Committee. It is supposed to have its best chance this year.

(3) Against S. 15522 (an outgrowth of the Kefauver hearings). Specifically against section 4 of the bill which would enable the Department of Health and Welfare to determine the efficacy of a new drug only in the light of its effectiveness under the conditions prescribed, recommended or suggested in the labeling. This in effect could enable congress or an agency, through administrative interpretation, to decide the relative effectiveness of a drug in terms of drugs already on the market or conceivably refuse to allow a drug to be marketed because it was, in their opinion, not the most effective drug for the purpose for which it was intended.

(4) H.R. 4930: Would provide federal scholarships for medical and dental students and set up construction grants for teaching and research facilities.

Dozens of bills that affect us directly as physicians or as citizens are being analyzed and spoken on by the AMA to the appropriate House and Senate committees. Among these are (1) a bill to establish a chiropractic section in the Medical Corps of the Army —giving the chiropractor a first rank of Second Lieutenant in the Medical Corps. (2) To increase Medicare privileges for dependents of members of the armed forces after they have been discharged from the armed forces (3) To move the determination of disability under Social Security relative to freezes and benefits, from state agencies to a federal agency under the Department of Health, Education and Welfare. These are bills on water pollution, bills requiring automobiles to meet certain federal safety specifications, ad infinitum. Sometimes these issues are genuinely designed for the benefit of the citizens, sometimes they are a frank bid for power by federal agencies. It behooves us as honest, intelligent citizens to be analytical and outspoken in our political beliefs at this critical time.

ACTIVITIES OF THE COMMITTEE have been directed chiefly toward creating an awareness of medicine's situation on the national level and an awareness of their potential as individuals and as county organizations.

(1) A major move in this direction was made in the spring of 1961 by sending our field representative, Mr. Bobbie Grogan, out into 18 of the 38 state senatiorial districts to meet with each sub-district key man and his county key men, trustees, and other interested physicians in the area to fully explain our position, and our program. These meetings were surprisingly well attended, a great deal of interesting and clarifying discussion was created and much stimulus was given to our efforts. A major item of discussion was the Kerr-Mills Law and the importance that its successful implementation would have in proving the lack of need for King-Anderson legislation, Kentucky being one of the early states to use it, lots of publicity had been given to the problems surrounding its use here.

(2) The Key Men, Officers and Staff of Kentucky State Medical Association, met, in February, with their Senators, Congressmen and wives in Washington at an informal dinner. This meeting, as have those in the past, was attended by almost 100 per cent of our legislators. This meeting of groups is felt to be one of the most effective methods of congenial ex-

change of ideas and information that has been devised by our Association.

(3) Direct action was taken during a meeting on June 21, 1961 to try to prevent the transfer of property from Nichols General Hospital to a group of chiropractors. Its transfer, through the offices of Health, Education and Welfare for a "token" payment, is to be, ostensibly, for the establishment of an educational center. The legal and moral basis for this transfer was seriously questioned at a personal meeting between Secretary of Health, Education and Welfare Ribbicoff and members of the Kentucky State Medical Association on June 28, 1961. The meeting accomplished little and it was decided by this committee that future action on this problem should be determined by the Board of Trustees.

(4) Weekly bulletins have been published in an effort to keep key members up-to-date on political matters and to point out areas of action which may be most effective at that time.

THE AREAS OF DANGER FACING US AS PRIVATE PHYSICIANS and as an association of physicians are many and varied and we must be able to recognize our antagonists and the devices they are using to accomplish their goals.

1. Congressman Forand, although out of the legislature, continues his efforts to promote HR 4222 by organizing the various aging clubs which were used in President Kennedy's campaign for use in influencing legislation in their behalf. Offers of financial aid by unions have been refused because Congressman Forand wants their program to be "spontaneous" and not dominated by any group—I suppose this means other than himself.

2. Senator Pat McNamara (Michigan) is in a dangerous posistion as chairman of the Senate Special Committee on Aging and is an outspoken proponent of medical care under Social Security. It is felt that he is a spokesman for labor and has recently released an outright appeal as head of this committee by stating "Increasingly, they (the aged) are turning to their elected officials for some form of public action. Their letters reaffirm their desire for the RIGHT to medical care through Social Security." I have a feeling these letters are from the aged groups that Mr. Forand dominates.

3. Wilbur J. Cohen, Assistant Secretary of Health, Education and Welfare, is one of the originators of the Social Security program and is currently active in increasing its scope without resorting to the pretense of doing so to protect the health of the aged. He is quoted as telling the press that it is not necessary to determine how many aged could not pay their medical bills, it would be evident soon enough when they applied for assistance. This was subject to some criticism from Secretary Ribbicoff. Cohen is one of the men who is alleged to have spent large sums of government money to propogandize for socialized medicine, has been affiliated with a number of subversive organizations and is one of the most powerful proponents of outright socialization of our national economy. (Information available on request.)

4. Secretary Ribbicoff himself apparently is doing everything in his power to promote the socialization of medicine—he is propogandizing with half truths and was reported in the New York Daily News as making a "veiled threat" to the graduating class of the University of California Medical School that "if doctors don't play along with the politicians in furnishing more 'free' medical care the politicians will take over the doctors."

The system of social security itself constitutes a threat by being subject to constant upward revision thereby appealing to millions of recipient voters who are apt to allow the federal elections to be dominated by those who promise the most appealing benefits to them. It has been documented that Wilbur J. Cohen has proposed enough social security programs that the social security withholding for a man making $9,000.00 yearly will be greater than his income tax.

5. These men in high places in government and various legislators who are "owned" by some labor organizations or who are for other reasons dedicated to the philosophy of socialization and a free wheeling liberal economy constitute a serious threat to free enterprise in our country.

OUR POTENTIAL FOR FUTURE ACTION is great if we rise to the opportunities facing us today. The major obstacles will be overcome if the facts so evident to many of us can be disseminated to every physician. This Council feels that if it can reach every doctor of medicine in Kentucky with the facts at its command the response will justify its existence. To this end the Council formally recommends the following to the House of Delegates.

1. The Washington dinners given by the Kentucky State Medical Association, key men, officials and staff for their elected legislators and wives be continued with payment of $100.00 toward expenses to the congressional district key-men.

2. That the Association contribute an honorarium of $500.00 to Edward R. Annis, M.D., in connection with his impending visit to Louisville in September.

3. The Board of Trustees assume responsibility for future action IN PREVENTING THE ACQUISITION OF 11 ACRES of Nichols General Hospital property by a group of chiropractors.

Part II—State Affairs

The Legislative Council held its first meeting December 8, 1960. The legislative contact system was revised and improved. As you know each congressional district has a key man appointed by the Board of Trustees. In addition, a sub-key man was appointed in each congressional district but this year they were assigned to each state senator within that district. Since our state senatorial districts are not the same as the congressional district, this particular procedure calls for several sub-district key men in some districts and overlapping in others. As before each county society has a key man but it was requested that each society elect rather than have their key man appointed for this year. Many of the specialty groups submitted to the legislative council the names of two physicians as consultants. There were many, however, that did not respond.

Most of the agenda at the state level has been plans for the coming Legislature in 1962. In accordance with directives from the House of Delegates, the following bills are proposed for the next session of the Legislature.

1. COMPULSORY IMMUNIZATION BILL: At the Legislative Council's last meeting (June 21, 1961) Mr. Gaines Davis presented a rough draft which was discussed. Several recommendations were made and Mr. Davis agreed to revise his draft incorporating these suggestions. He then would clear this bill with the attorney for the State Department of Health. The bill would then be presented to the Board of Trustees for their approval. The approved bill will also be mailed to each key man in order that they might discuss it with their senators and representatives getting a commitment if possible.

2. PRIVILEGED COMMUNICATION: KSMA's committee on maternal mortality has requested that the Legislative Council introduce a bill which would accord privileged status to that which is applicable to confidential communication between lawyers and client et cetera. KSMA's Hospital Committee is also interested in having similar legislation. Therefore, the Legislative Council and Legislative Committee authorized Mr. Davis to draft such a statement and bring it to our next meeting for discussion.

3. RENDERING EMERGENCY CARE BILL:

Such a bill was introduced at the last minute in the Senate (Senate Bill No. 160) by Senator Nick Johnson. Because of the lateness of the hour no stand was taken by KSMA and the bill was lost in committee. The Legislative Council therefore recommends to the Board of Trustees that this matter be taken under advisement and that Senate Bill 160 (which originated with Gene Bowling, M.D.) be suitably framed and endorsed.

At the last meeting of the Legislative Council with the Legislative Committee in accordance with a recommendation made by Mr. Gaines Davis a motion was made and passed that 200 copies of "Cult of Chiropractic" be purchased. These are to be distributed by the key men to each senator and representative. By this means it was felt that the true picture of chiropractors might be ascertained by our legislators.

The House of Delegates in 1960 passed a resolution instructing the Legislative Council to study the problem of Mail Order Drugs. Before any action was taken Mr. Bobbie Grogan was requested to contact Mr. Josey, Executive Secretary of the Kentucky Pharamaceutical Association. Mr. Josey advised: "So far no one has come up with an answer to the problem. Attorneys can't agree on a basic law because such a law would control the mailing of prescriptions by a retail drug store to customers on vacation. We are scheduled to have another meeting the 30th of September to discuss Mail Order Prescriptions and if any information comes out of this meeting worth passing on we will be glad to send the information to you. We do appreciate KSMA's interest in our problem." The Legislative Council plans nothing until after this proposed September meeting.

In accordance with a request received from President Richard Elliott, Senator C. W. A. McCann's bill No. 61. concerning safety belts for automobiles will be discussed at the next Council Meeting. Concerning this bill the KSMA's Highway Safety Committee will be our advisors.

In accordance with the wishes of the Legislative Council, Mr. Bobbie Grogan has been traversing the Commonwealth holding meetings with sub-districts and district groups, meeting key men and making as much personal contact as deemed necessary. This has proven to be a tremendous task and has kept Mr. Grogan out of contact with other phases of our legislative program. Because of this the Legislative Council recommends that Mr. Grogan be given immediate assistance at his discretion. In addition, it was felt that it would take as much time to oppose undesirable legislation at the next legislative session as it will to pass desired legislation. Also, we learned in the 1960 Session that it takes at least two men in Frankfort to properly fulfill our requirements. There are many times when we need a representative at two separate meetings at the same time. Therefore, the Council also recommends additional help that might be needed during the legislative sessions.

In closing I wish to report that a physician's league for political action, approved by 1960 KSMA House of Delegates, will be on the agenda for future meetings to set up acceptable plans. This has been discussed in the past but nothing concrete has been recommended. We feel that with help from the newly formed American Medical Political Action Committee we can get such a committee started in this state. (Mrs. Earl W. Roles, President of the Women's Auxiliary of KSMA is a member of the Board of this newly formed organization.)

Council on Legislative Activities
George P. Archer, M.D., Prestonsburg
Chairman (Presently Inactive)
J. Duffy Hancock, M.D., Louisville
Wyatt Norvell, M.D., New Castle
John Quertermous, M.D., Murray
Acting Chairman—National Affairs
Robert D. Shepard, M.D., Lexington
Chairman—State Affairs

Recommendation of the KSMA Board of Trustees

The foregoing report is forwarded to the House of Delegates with the recommendation that the Council's report be approved and implemented with the following exception; with respect to the recommendation that Mr. Grogan be given immediate assistance in traveling over the State and also additional help during the legislative sessions, it was moved, seconded and carried that the Legislative Council be authorized to secure such help, as needed, at the appropriate time, in consultation with the Executive Committee as to financial arrangements. No further action by the House with respect to this recommendation is therefore required.

Recommendations, Reference Committee No. 3

This report is divided into two parts . . . Part I, National Affairs . . . Part II, State Affairs.

Part I

Efforts on the part of the Council on Legislative Activities at the National Level were directed toward keeping the practice of medicine as a private enterprise. The informed know that our system of medicine is unexcelled in the entire world even though some will not admit it for various reasons. No doubt, the task of keeping medicine free this year was alleviated to some degree by the advent of the Kerr-Mills Law. It behooves all of us to participate in this program even though we may not completely agree on how this type of legislation should be implemented. We believe you will agree that the people eligible under the Kerr-Mills Law are the ones who need financial help.

Opposing and keeping in Committee the King-Anderson Bill was the primary objective of our Council this year, but there were many other bills introduced into the 87th Congress which directly affected us as physicians. Some of these bills our Council was in favor of and others they rightfully opposed. They are too numerous to enumerate here, but one of them we must call your attention to: To establish a Chiropractic Section in the Medical Corps of the Army giving the chiropractor a first rank of second lieutenant in the Medical Corps. The Legislative Council also kept our field representative, Mr. Bobbie Grogan, on the move. He was sent out to explain to the physicians why the Kerr-Mills Law must be made work.

The Council, Legislative Key Men, Officers and staff of the Kentucky State Medical Association, met in February, with our Senators and Congressmen and their wives in Washington, D.C. at an informal dinner. The Council opposed, and rightfully so, the transfer of surplus property from Nichols Hospital to a group of chiropractors for an educational and treatment center.

The Council published weekly Bulletins in an effort to keep the Legislative Key Men up-to-date on political action and to advise them on the action to be taken. We would like to point out here that this Council has done an excellent job on keeping the key men informed. Please remember that the Council, our officers and the Legislative Key Men cannot fight this battle alone—It requires the entire membership of the Kentucky State Medical Association, plus all of our friends.

Some of the outspoken proponents of medical care under the Social Security System in Washington, D.C. are:

1. Authors of the King-Anderson Bill
2. Senator Pat McNamara (Michigan)
3. Wilbur J. Cohen—Assistant Secretary of Health, Education and Welfare
4. Secretary of Health, Education and Welfare—Ribicoff
5. Former Representative, Aime Forand (Rhode Island)

6. The Executive branch of the Administration and many members of the House and Senate.

Recommendations of the Council on Legislative Activities on the National Level were approved by the Reference Committee as written in the report.

Reference Committee No. 3 recommends that the Kentucky State Medical Association promote a statewide educational program on chiropractic claims and advertising of qualifications in the treatment of various conditions.

Mr. Speaker, I move the adoption and implementation of this section of the report. Motion seconded and carried.

Part II—State Affairs

The Council on Legislative Activities revised the Legislative Contact System. The Congressional District Key Men were appointed by the Board of Trustees. The District Key Men recommended Sub-District Key Men for each of the State Senatorial Districts in their Congressional District for approval by the Board of Trustees. The County Key Men were elected by the county medical societies this time rather than being appointed by the Key Men.

Since the State Legislature did not meet this year most of the action on the State Level was directed toward the 1962 Session of the General Assembly. The Council on Legislative Activities, in compliance with direction of the 1960 House of Delegates, has prepared and is expecting to introduce a Compulsory Immunization Bill. Also prepared and ready for introduction is a bill to relieve physicians, and other persons, of liability for first aid and emergency care rendered at the scene of an accident.

Legislation on the subjects of Privileged Communication, Mail Order Drugs, and Compulsory Installation of automobile Seat Belts is still under consideration by the Council and appropriate committee. Your Reference Committee, therefore, considers that no further action by the House of Delegates is required on any of these legislative matters at this time.

The Kentucky State Medical Association Board of Trustees made the following recommendation:

"The foregoing report is forwarded to the House of Delegates with the recommendation that the Council's report be approved and implemented with the following exception; with respect to the recommendation that Mr. Bobbie Grogan be given immediate assistance in traveling over the State and also additional help during the Legislative Sessions, it was moved, seconded and carried that the Legislative Council be authorized to secure such help, as needed, at the appropriate time, in consultation with the Executive Committee as to financial arrangements. No further action by the House with respect to this recommendation is therefore required."

Mr. Speaker, I move the adoption of this section of the report with full implementation of the recommendation of the Board of Trustees. Motion seconded and carried.

Council on Medical Education and Hospitals, Hospital Committee

(3) Privileged Communications. The Hospital Committee recommends that the Council back the other councils and committees in their thinking regarding privileged communications and we recommend that the Council recommend that legislation be introduced in the 1962 General Assambly which would define the ownership of the hospital chart, what constitutes the hospital chart and what portion of information on the chart should be released to the insurance companies and the press. They further recommend that any legislation along these lines should be done with the approval and cooperation of the Kentucky Hospital Association.

Recommendations, Reference Committee No. 3

On page eight, paragraph three, of Report No. 11 the Hospital Committee recommended that the Association consider introduction in the 1962 General Assembly legislation which would define the ownership of the hospital chart, what constitutes a hospital chart and what portion on the hospital chart should be released to insurance companies and the press. The Council felt that this matter should receive further study and the Board of Trustees concurred. This Reference Committee endorses the recommendation of the Council and Board of Trustees.

Mr. Speaker, I move the adoption of this section of the report. Motion seconded and carried.

Council on Medical Services—Insurance Committee

Another matter that this Committee has been quite interested in is the provision in the Kentucky Revised Statutes that permits a municipality to tax companies selling health insurance. This statute has not been adhered to, however, there has recently been formed a Kentucky Municipal League. This League is now attempting to have Blue Shield and Blue Cross pay a tax on the premiums that they collect from the citizens in Kentucky. It is the feeling of the Insurance Committee that this is an unjust tax because it is levied on people who are trying to prepay their medical bills under a prepayment plan. We feel that this will defeat the very purpose of prepaying our voluntary health insurance and that the KSMA should undertake to have legislation of this sort repealed.

Recommendations, Reference Committee No. 3

The Insurance Committee recommended that the provision in the Kentucky Statutes that permits the municipaltities to tax insurance companies selling health insurance be repealed. The Council adopted this recommendation and its recommendation was approved by the Board of Trustees.

We understand that action is being taken by Blue Shield, in cooperation with other insurance companies, and we recommend that they continue with their negotiations.

Mr. Speaker, I move the adoption of this section of the report. Motion seconded and carried.

Council on Medical Services—Aging Committee

1. The KSMA give firm backing and support to the Citizens Commission on Aging, and we would specifically recommend that the KSMA endorse any proposed legislation in the 1962 General Assembly that would tend to establish this Commission as a permanent body under statutary regulations.

Recommendations, Reference Committee No. 3

The Committee on Aging recommended that KSMA endorse appropriate legislation which might be proposed in the 1962 Legislature which would establish this Commission on Aging as a permanent body under statutory regulations.

The Council and Board of Trustees approved the Committee's recommendation and we concur in their recommendation.

Mr. Speaker, I move the adoption of this section of the report. Motion seconded and carried.

Council on Communications and Public Service—School Health Committee

3. That we support legislation in regard to compulsory immunization against poliomyelitis, tetanus, diphtheria and pertussis.

Recommendations, Reference Committee No. 3

The School Health Committee recommended that we support legislation in regard to compulsory immunization against poliomyelitis, tetanus, diphtheria and pertussis. The Council and Board of Trustees approved this recommendation.

Such legislation was approved by the 1960 House of Delegates and a compulsory immunization bill is

ready for presentation to the 1962 General Assembly. This Committee feels this recommendation requires no further approval.

Mr. Speaker, I move the adoption of this section of the report. Motion seconded and carried.

Council on Allied Professions and Related Groups—Infant and Maternal Mortality Committee

The committee on Infant and Maternal Mortality of the Kentucky State Medical Association has held two meetings so far this year and will have a third meeting some time during the KSMA Annual Meeting in September. It is planned to have a complete statistical review of the work done by the committee since the beginning of our study some five or six years ago. We also plan to have a panel discussion with the presentation of perhaps two cases. The number of deaths reported thus far for 1961 is 23.

At our meeting in March we invited Mr. Gaines Davis, our legal counsel, to speak to us on the legal aspects relative to privileged communications. Although Mr. Davis was of the opinion that we were relatively safe without such a statute, he advised that it would perhaps be an added safeguard against possible litigation. The committee voted to proceed with whatever necessary to get the desired legislation enacted. The chairman then appointed a committee of Louisville doctors to contact the Council on Allied Professions and Related Groups and to ask that the Council communicate with the Board of Trustees. It was brought out that there were some other groups planning some special legislation and perhaps all of the desired legislation could be combined in one bill.

Recommendations, Reference Committee No. 3

The Infant and Maternal Mortality Committee recommended certain legislation on privileged communication. The Council recommended that the entire matter of privileged communication be referred to the Council on Legislative Activities, and its report was approved by the Board of Trustees. This Committee concurs in this action.

Mr. Speaker, I move the adoption of this section of the report. Motion was seconded and carried.

Mr. Speaker, I move adoption and implementation of the report as a whole. Motion seconded; carried.

Reference Committee No. 3
F. R. Scroggin, M.D., Dry Ridge, Chairman
Melvin Bernhard, M.D., Louisville
Robert Pennington, M.D., London
Robert D. Shephard, M.D., Lexington
Paul J. Sides, M.D., Lancaster

REFERENCE COMMITTEE NO. 4

David Thurman, M.D., Chairman
Reports on Public Service and Allied Professions

Report of the Council on Communications and Public Service

PREFACE

Chapter VII, Section 4, of the KSMA Bylaws as revised in 1960, relating to the reorganization of the committee structure, reads in part:

". . . Each standing committee and Council shall report annually, at least six weeks prior to the Annual Meeting, to the House of Delegates via the Board of Trustees respecting its activities during the year last past. These reports shall be transmitted without alteration or amendment, to the House of Delegates by the Board of Trustees at the Annual Meeting, with such comments or recommendations as the Board cares to make. . ."

The material in this report of the Council on Communications and Public Service is presented in the following order:

1. Actions and recommendations by the Council which it undertook on its own initiative.
2. Reports of the committees of this Council with the Council recommendations following each committee report.
3. Recommendations by the KSMA Board of Trustees on the over-all contents at the conclusion of the report.

The Council on Communications and Public Service has held two (2) meetings in this associational year. As chairman, I would like to express my appreciation to the members who have given so unselfishly of their time and talents to the business of this Couicil.

There are eight committees serving under the Council on Communications and Public Service; Rural Health, Diabetes, Emergency Medical Services, School Health, Public Health, Senior Day, Advisory to Woman's Auxiliary and Highway Safety Committee.

Our Council has enlarged its area of activities in the placing of exhibits of a health nature at various meetings, shows or conferences. Exhibits this associational year have been shown at the Annual KEA Meeting in Louisville, the Home Show in Louisville, the PTA meeting in Louisville, the County Health Fair in Wolfe County, the KSMA Annual Meeting and the Kentucky State Fair. At all times our Council has made an effort to have exhibits which would be both interesting and instructive.

Plans have been made for the Third Annual New Members Luncheon, to be held in Louisville on Tuesday, September 19, as an integral part of our Annual Meeting. From all indications, this program is serving a useful purpose in giving our new members a broader perspective of the KSMA.

"Benefits to You as a member of the Kentucky State Medical Association," a booklet which is given to all new members coming into the Association, has been revised by our Council and is now available for distribution from the KSMA Headquarters Office.

Over 5,000 copies of the AMA booklet, "The ? Cost of Medical Care" have been distributed by our Council to KSMA physicians throughout Kentucky. This has proven to be one of the most accepted publications our Council has furnished KSMA members.

The Council is also planning to send each County Society Secretary a copy of the Pennsylvania Emergency Call Plan with the suggestion that this be used as a guide in setting up a similar call plan, particularly for the larger societies.

It was recommended to the 1960 House of Delegates by the Committee on Public Information and Service that the organization known as the American Association of Medical Assistants be officially sanctioned and approved by the House of Delegates. This matter was again submitted to our Council by the Executive Committee of the Board after the 1960 House of Delegates asked that this matter be given further study. This has been discussed five times by the Council and the old Committee on Public Information and Service. By endorsing this group, the Committee felt that a closer relationship could be maintained and assistance and supervision could be given by the local medical society involved. The Jefferson County AAMA has been in operation for several years and reports emanating from the physicians in this area are enthusiastic in its support. The opposition voiced to KSMA approval of this group is on the basis that there is a possibility that the AAMA could become a bargaining instrument in the hands of pressure groups to be used against organized medicine. However, the Constitution and Bylaws definitely state that this organization can never become a bargaining agency. This Council recommends to the House of

Delegates, through the Board of Trustees, that recognition and approval be given to the AAMA by the KSMA.

The 1960 House of Delegates did again reaffirm the recommendation of the KSMA Advisory Commission to Blue Shield that physicians list the charge made by them for the service rendered to a patient, when filling out the Blue Shield claim form. The Executive Committee of the KSMA Board of Trustees, at the October 20, 1960 meeting, referred this matter on to this Council for implementation.

Our Council has discussed this matter on two occasions and it was the unanimous opinion of all those present at both meetings that they were opposed to listing such fees for the following reasons:

1. Since this is an indemnity plan, it is our belief that there is no useful purpose to be served by listing such charges.
2. This would tend to standardize fees without individualizing services rendered.
3. In essence such a listing of fees might be used in the establishment of a relative value scale, which has been opposed by the Kentucky State Medical Association.

This Council, therefore, recommends to the KSMA Board of Trustees and the House of Delegates that it reconsider its action taken at the 1959 and 1960 Annual Meetings on the listing of these fees by the members of this organization.

Following a directive from the Executive Committee of the Board of Trustees that a public educational campaign should be conducted that will inform the public more fully on cults as to their training, theory of treatment, etc., the Council has collected all information which it could find on cults, and it specifically recommended that a new "Committee on Cults and their Activities" be created with the objective of keeping abreast of cults and their activities and that this committee serve under the Council on Communications and Public Service. We would ask that all of the Councils survey advertising and other activities of cults and that this information be referred to this new committee.

The following reports of the committees serving under the Council are herewith submitted:

Rural Health Committee, Mitchell B. Denham, M.D., Hopkinsville, Chairman

The Rural Health Committee at its only meeting of the year discussed the prior year's conference at Morehead on October 27, 1960, which attracted a total registration of 174 from 30 counties and 4 states.

As in the past, special promotional efforts will be stressed in certain counties for the 1961 Conference, which will be held at Kentucky Dam Village on November 2, 1961 and the Conference will be devoted to Tuberculosis and Dental Care.

Council Action: It is the recommendation of the Council that the report of the Rural Health Committee be accepted as presented by the committee.

Diabetes Committee, Robert S. Tillett, M.D., Louisville, Chairman

The Diabetes Committee met once during the year and agreed that the 1961 Diabetes Detection Week will be November 12-18.

The 1960 drive reported that 54,922 tests were made and that 234 new diabetics were reported.

Council Action: It is recommended by the Council that the committee report be accepted and that this program continue to be encouraged.

School Health Committee, Caroll L. Witten, M.D., Louisville, Chairman

This committee has already met once and has another meeting scheduled for August 12, in Lexington. Plans have been laid for the 1961 Athletic Injury Prevention Conference to be held in Lexington on August 12 in conjunction with the annual U.K. Coaches Clinic.

Four recommendations were submitted to the Council for its approval as follows:

1. That the Athletic Injury Conference be continued primarily along the same procedure as in the past and that a similar program of this sort be presented for coaches and the medical profession somewhere in Western Kentucky, provided this meets with the approval of the Kentucky High School Athletic Association.
2. That a minimum physical education program would be a period of calisthenics for grades 1 through 8.
3. That we support legislation in regard to compulsory immunization against poliomyelitis, tetanus, diphtheria and pertussis.
4. That the Senior Day Committee give consideration to bringing the activities of the School Health Committee before the seniors and stressing that it is one of the obligations of a physician to participate as a team physician in athletic programs.

Council Action: It is recommended that this report be accepted and the above four recommendations be endorsed by the KSMA.

Committee on Emergency Medical Services, Morgan Colbert, M.D., Louisville, Chairman

There have been no meetings of this committee to date. The chairman has met twice with the Jefferson County Disaster Planning Committee and it is felt that plans being made in Louisville are somewhat similar to those needed elsewhere in the state.

The setting up of field organizations has been done quite successfully in other states and cities, especially Washington, D.C., and is operational at present.

Tentative planning is being done in connection with public health officers toward meeting later this year.

Council Action: It is recommended that this report be accepted.

Public Health Committee, Delmas M. Clardy, M.D., Hopkinsville, Chairman

This committee has accomplished a few important matters other than the routine annual immunization program since our last report.

It appears that the immunization program—May 7-14 has received more publicity than last year. Perhaps this is because the AMA was active in the promotion of poliomyelitis immunization and much national publicity was evident. It seems that all news media were liberal with this fine public service.

In its 1960 session, the House of Delegates voted to support legislation for compulsory immunization of Polio, Pertussis, Diphtheria and Tetanus. This committee, at its March 23 meeting, discussed this subject with the Commissioner of Health, Doctor Teague and the Louisville-Jefferson County Health Officer, Doctor Kamp. All agreed that compulsory immunization is necessary and that legislation should be enacted.

Doctor Kamp's objection all along was connecting the program with school attendance. The first year of life is the time to start the immunizations and this will have to be done with the cooperation of the Health Department and Birth Registrations Section. This has already been discussed with the KSMA attorney who is writing the bill. The committee recognizes the fact that the bill will have to meet the approval of the Board of Trustees.

Last year this committee suggested that it would be in order for the KSMA to have a Highway Safety and Automobile Accident Prevention Committee. The House of Delegates authorized the appointment of this committee and a very active committee with a very capable chairman was appointed by the Board of Trustees.

Fluoridation of public water supplies is another important item in which this committee has been interested. There are 38 cities in Kentucky that have

fluoridation. The committee is working on a few projects with the Dental Association to increase the interest.

A public law to enforce fluoridation might be considered after the immunization law is in effect. A few uninformed people should not be able to deprive future generations of good teeth and dental health.

Council Action: It is recommended that the report be accepted and that the KSMA Headquarters Office order a supply of speakers' kits from the AMA or the ADA that could be used by individual physicians in appearing before local groups in discussing the merits of fluoridation and that the availability of these kits should be carried in Newscaps.

Senior Day Committee, Carl Cooper, M.D., Bedford Chairman

The 1961 Senior Day Program was held in Louisville on March 20, 1961 and was well attended and, from all reports from the senior students, the program was very good.

In an attempt to give the senior medical students the type of program they would like to have, a new innovation was added to this year's program. Questionnaires were distributed to all present, asking for their frank comments on the speakers and also what, in their opinion, are the most important areas to cover. A great deal was learned from these questionnaires and they will be turned over to the next Senior Day Committee for their perusal.

Council Action: It is recommended that the report of the Senior Day Committee be accepted.

Woman's Auxiliary, J. A. Bishop, M.D., Jeffersontown, Chairman

This committee has not met during the year but the chairman has been contacted by the President of the Woman's Auxiliary relative to the Auxiliary becoming a member of the Kentucky Health Council.

Council Action: It is recommended that this report be accepted and that the KSMA Auxiliary be encouraged to become a member of the Kentucky Health Council.

Highway Safety Committee, Arthur H. Kenney, M.D., Louisville, Chairman

This is a new committee of the KSMA, which was authorized by the 1960 House of Delegates and wasn't officially formed until the April 27, 1961 meeting of the Board of Trustees.

One of the first functions of this committee was to send 500 post cards to the Jefferson County physicians and 26 post cards to the Christian County physicians. Sixty-six per cent of the cards were returned from Jefferson County and 69% from Christian. These cards contained the following questions:

1. Do you have seat belts in your family and personal cars?
2. Do you use seat belts, always, occasionally, out of town only, none?
3. Do you urge your patients to use seat belts?
4. Do you believe in seat belts?

This survey indicated that 34% of the physicians answering in Jefferson County use seat belts while 92% believe in seat belts. The committee thought this to be very encouraging and that prior to starting a public campaign, we should first have our own house in order and that the basic effort of this committee should be first to encourage more physicians to use seat belts. Nationally, approximately 2-4% of the general public use seat belts.

In order to create more physician interest in seat belts the committee would like to send a letter to each individual physician in Kentucky giving him the results of the post card survey and a brief report to date on what has happened and what is needed and that also this committee enlist the aid of the Woman's Auxiliary, providing this meets with the approval of the Council.

Other points that this committee has studied is the role of the optometrists in highway safety. It is noted that optometrists have pushed highway safety for many years and that they may introduce a bill in the 1962 legislature asking for visual analysis of each driver and that they have set up a relative value scale that the optometrists can use in doing different procedures in this connection. They have asked that a committee from KSMA meet with them to discuss visual standards but it is the opinion of the KSMA Highway Safety Committee that such a meeting would be fruitless because we are going different ways and prior meetings with this group have produced no results.

It is anticipated that an obligatory seat belt bill will be introduced in the 1962 General Assembly but it is the opinion of the committee that it would be reluctant to endorse such a bill of a compulsory nature inasmuch as it is hard to legislate safety by compulsory measures, and it is felt we first need more in the way of educational programs.

The problem of alcoholism and epileptics have also been discussed by this committee but it is the thinking of the committee that at the present time this committee should not get into this area to a large extent. The discontinuance of laminated safety glass in automobiles by the industry was discussed and we consider this to be unfortunate and a step which bears medical observation concerning injuries by glass fragments.

Our committee further recommends that the KSMA, in cooperation with the Kentucky State Police, unite in an effort to promote safety. This could be accomplished by having certain road rest stations on roads coming into Kentucky on July 4, 1962—stop all cars from out of state—welcome them to Kentucky—give them a coke—pass out a pamphlet such as the importance of seat belts and perhaps use a slogan such as "We Want You as Visitors—Not Patients." This would necessitate the cooperation of physicians in these cities and could only be done if the Kentucky State police approve of the idea and would so cooperate.

To carry out these programs, we would request that $500 be allocated to this committee for expansion of a safety program.

Council Action: It is recommended that the program as presented by the Highway Safety Committee be adopted. We agree that our efforts should first be directed to the medical profession and that funds should be available to this committee in order to carry out their programs.

The Council on Communications and Public Service would like to especially commend the committees that have served under this Council for their work during the associational year. We feel that our new table of organization is an excellent framework for better activity and accomplishment.

Under the Bylaws of the Association, this Council is charged with supervising and directing all associational activity in the fields of public relations and service. Let us remember that our best public relations are by the individual physician himself in his daily role of contact with his patients.

The word COMMUNICATIONS is all important and we would urge that all physicians read all material that comes from the KSMA Headquarters Office, Councils and the Board of Trustees. Our primary media of communicating with you is through the mail and by proper communications only can all of us be informed as to all activities of the association.

Council on Communications and Public Service
J. Auldin Bishop, M.D., Jeffersontown
Morgan Colbert, M.D., Louisville
Carl C. Cooper, M.D., Bedford
Mitchell Denham, M.D., Maysville

Robert S. Tillett, M.D., Louisville
Carroll Witten, M.D., Louisville
N. L. Bosworth, M.D., Lexington, Chairman

Recommendations by the KSMA Board of Trustees

The foregoing report is forwarded to the House of Delegates with the recommendation that the Council's report and the report of each of its committees be approved and implemented with the following exceptions:

(1) The Board neither approves nor disapproves the recommendation of the Council that the House of Delegates reconsider its action taken at the 1959 and 1960 Annual Meetings on the listing of fees for services rendered to a patient while filling out Blue Shield claim forms.

(2) The Board feels that, because the 1960 House of Delegates approved support of compulsory vaccination, the recommendation of the School Health Committee that KSMA support legislation in regard to compulsory immunization is moot. Legislation on this subject is presently being drawn up and will be submitted to the 1962 General Assembly with KSMA support.

Supplemental Report of the KSMA School Health Committee

(Council on Communications and Public Service)

NOTE: This supplemental report is necessary due to the School Health Committee having a meeting on August 12, 1961, which was after the original report had been submitted to the KSMA Council on Communications and Public Service.

The 1961 Athletic Injury Conference, held in Lexington on August 12, attracted approximately 150 physicians, coaches, trainers and others interested in athletic medicine. At the request of the K.H.S.A.A. and also the Western College coaching staff, it is felt that a similar type conference will be presented at Bowling Green later in the fall.

Also discussed at this meeting was a request from the AMA's Committee on the Medical Aspects of Sports concerning Kentucky being a "pilot" state in increased physician participation in athletic medicine. It was noted that in line with this request, an athletic symposium will be presented during the 1961 Annual Meeting and that Owen B. Murphy, M.D., Lexington, has indicated that he would be willing to appear before the various county societies to discuss athletic injuries and their prevention. It was felt that the KSMA should do all possible to make our programs a standard that could be followed in other states.

A special guest of the committee at this meeting was Mr. Lee Gentry, Supervisor of Health, Safety and Physical Education, State Department of Education, who discussed the present status of physical education in Kentucky schools.

After a lengthy discussion on this matter and following a request from Mr. Gentry, the attached resolution was adopted and it is recommended by the School Health Committee that this resolution be endorsed by the House of Delegates as it is felt that we need to speak out on the matter of physical education for our youth.

Resolution on Physical Education

WHEREAS, the physical and mental well being of the people of Kentucky is of great importance and a natural concern of the medical profession, and

WHEREAS, the strength of our nation itself directly depends on this same physical and mental health of all Americans, and

WHEREAS, an expanded well planned and implemented physical education program, concentrated efforts on physical fitness through calisthenics and other planned programs would aid greatly in the promotion of physical fitness, and

WHEREAS, the State of Kentucky has made great strides in the field of physical education with the standards established by the Kentucky Department of Education, and

WHEREAS, this program could easily be expanded to more completely fulfill the needs of our school children,

NOW THEREFORE be it resolved, that the Kentucky State Medical Association strongly endorses the principle of increasing the physical educational requirements in our schools by instituting a formal calisthenics planned program, beginning with grade one, and further

BE IT RESOLVED, that the KSMA commends the Kentucky Department of Education on the excellent progress it has made in the past few years in this important field of physical education and in its emphasis thereon, and that we do offer the support and endorsement of the medical profession of our State to further increase the physical educational requirements that would thereby greatly aid in the promotion of physical fitness and well being in the children of our Commonwealth.

Recommendations, Reference Committee No. 4

Report of the Council on Communications and Public Service, No. 14. The committees included in this Council's report are:

Rural Health
Diabetes
Emergency Medical Services
Highway Safety
School Health
Public Health
Senior Day
Advisory to Woman's Auxiliary
Highway Safety

This Reference Committee read with pleasure the varied activities of the Council on Communications and Public Service. It was noted that the Council carried on Health Education activities, promoted a new member luncheon, issued a new brochure and had distributed more than 5,000 copies of the booklet entitled "The ? Cost of Medical Care."

Mr. Speaker, I move the adoption of this section of the report.

A discussion on the acceptance and approval of the AAMA followed. At this point, a substitute motion was offered as follows: "That KSMA adopt this section of the report, except that it is the sense of the House of Delegates that the American Association of Medical Assistants should be and is approved by KSMA." The motion was seconded and carried.

Mr. Speaker, that section of Report No. 14 relating to the KSMA Advisory Commission to Blue Shield was referred to another Reference Committee.

Rural Health Committee

This committee studied the report of the Rural Health Committee and would like to compliment it on its good work.

Mr. Speaker, I move the adoption of this section of the report. Motion seconded and carried.

Diabetes Committee

The Diabetes Committee reported that KSMA members had completed approximately 55,000 tests during 1960 and that 234 new diabetics had been discovered.

Mr. Speaker, I move the adoption of this section of the report. Motion seconded and carried.

School Health Committee

All of this report was considered by our committee except paragraph No. 3 on page 5. This paragraph was referred to another reference committee.

The committee notes the activities of this committee in the promotion of the Athletic Injury Con-

ference, the minimum physical education program and the recommendation on Senior Day and believes that they should be approved.

Mr. Speaker, I move the adoption and implementation of this section of the report. Motion seconded and carried.

Committee on Emergency Medical Services

It was noted that, while this committee had held no meetings, the chairman had met with the Jefferson County Disaster Planning Committee and other programs in this field were noted.

Mr. Speaker, I move the adoption of this section of the report. Motion was seconded and carried.

Public Health Committee

This committee wishes to applaud the work of the Public Health Committee on carrying on the immunization program and its support of legislation for compulsory immunization.

It also notes that this committee successfully supported the formation of a Highway Safety Committee.

Mr. Speaker, I move the adoption of this section of the report. Motion was seconded and carried.

Senior Day Committee

This committee was impressed with the report of the Senior Day Committee and recommends its continuance.

Mr. Speaker, I move the adoption of this section of the report.

Advisory Committee to Woman's Auxiliary

It was noted this committee has not met during the year but the chairman has been contacted by the President of the Woman's Auxiliary a number of times during the year for advice.

Mr. Speaker, I move the adoption of this section of the report. Motion seconded and carried.

Highway Safety Committee

This committee read with pleasure the fact that the Association has activated the Highway Safety Committee and heartily supports its program. This committee wishes to emphasize that section of the report of the Highway Safety Committee which deals with the problem of laminated safety glass and makes this recommendation:

We strongly disapprove the discontinuance of laminated safety glass in automobiles by the auto industry and recommend that this be referred to the Highway Safety Committee and to the Board of Trustees for further consideration.

Mr. Speaker, I move the adoption and implementation of this section of the report. Motion was seconded and carried.

Report of the Council on Allied Professions and Related Groups

PREFACE

Chapter VII, Section 4, of the KSMA Bylaws as revised in 1960, relating to the reorganization of the committee structure, reads in part:

". . . . Each standing committee and Council shall report annually, at least six weeks prior to the Annual Meeting, to the House of Delegates via the Board of Trustees respecting its activities during the year last past. These reports shall be transmitted without alteration or amendment, to the House of Delegates by the Board of Trustees at the Annual Meeting, with such comments or recommendations as the Board cares to make . . . ."

The material in this report of the Council on Allied Professions and Related Groups is presented in the following order:

1. Actions and recommendations by the Council which it undertook on its own initiative.
2. Reports of the committees of this Council with the Council recommendations following each committee report.
3. Recommendations by the KSMA Board of Trustees on the over-all contents at the conclusion of the report.

* * * * *

The Council on Allied Professions and Related Groups has held two meetings during the associational year with the first meeting being devoted primarily to an over-all discussion of the committees serving under this Council as to their functions and possible activities. The last meeting of this Council was held in July and at this time reports were received from the various committees assigned to this Council.

According to Chapter 7, Section 17, of the KSMA Bylaws, the Council on Allied Professions and Related Groups shall concern itself with the development and promotion of improved health standards and shall establish and maintain liaison with the dental, nursing and pharmacy professions in this state. It shall supervise and direct the Association's activities in the fields of infant and maternal mortality, physical medicine and rehabilitation, industrial medicine, tuberculosis, blood banks and other related subjects, and shall interest itself in the work of voluntary health associations.

Submitted below are the reports of the various committees serving under this Council, as presented by the committee chairmen, and also the thinking of the Council on each of these committee reports. These are as follows:

Blood Banks Committee—Marion F. Beard, M.D., Louisville, Chairman

In the opinion of the chairman, there has been no specific material or business referred to the committee this year that needed any specific action and, consequently, it was not deemed important enough to warrant a meeting of the committee. The chairman of the committee noted that the American Association of Blood Banks is getting active and is hoping to tie together small blood banks all over the country and he can see that in the future this may be an area for action by the state committee.

It was further noted by the chairman that he had attended a meeting in Indiana and that the AFL-CIO in that state is becoming very interested in blood banks and transfusions and that they are interested in all of Indiana being covered by community blood banks (a community blood bank would be one that would cover more than one community and would serve as a central clearing house for blood). It is believed that the trend is going in this direction of community blood banks and, if so, this may present some problems for action by the committee in the future.

Council Action: The Council accepts the report of the committee on Blood Banks and recommends that this committee be held in readiness in case there are areas for its jurisdiction in the forthcoming future.

Dental — Nurse — Pharmacy Committee — Walter R. Johnson, M.D., Paducah, Chairman

During the past year there have been no special problems presented to this committee. Various pieces of correspondence have been received and noted.

Of interest to KSMA is a committee on Professional Nursing Practice established by the KSARN to foster better ethical standards of nursing practice. This committee is also to receive and take appropriate action upon any complaints related to nursing practice from the public and from the profession.

Your committee has carefully considered a questionnaire received from the Judicial Council of the

AMA concerning physicians owning pharmacies or owning an interest in the pharmaceutical operations. This questionnaire was answered and most of it had to do with wanting to know if the KSMA had received complaints regarding the ownership of pharmacies by doctors of medicine or have complaints been directed to the Association regarding the ownership of pharmaceutical companies by doctors of medicine. It was felt that there have been no complaints in this area and the AMA Judicial Council was so notified to this effect.

Another question posed by the AMA Judicial Council was "May we have the benefit of your own thinking on this matter; should policy be modified; should state associations become more active in policing the practices of physicians who own pharmacies or pharmaccutical companies; what is your frank opinion on this matter?"

This question was answered that at the present time it is felt the policy established by the House of Delegates of the American Medical Association is adequate and sound. We have several areas in Kentucky that are sparsely populated in which no pharmacies are available and it is therefore necessary that physicians prescribe and supply drugs in these regions. Our opinion is that it is not unethical for physicians to dispense drugs or own pharmacies or invest in pharmaceutical corporations provided there is no exploitation of the patient. Any abuses should be handled by the appropriate committee of the County Medical Society first and secondly by the State Medical Association.

We wish to particularly thank Doctor VanMeter for his interest in this committee and his readiness to cooperate at any time. The state office of the KSMA has, likewise, been most helpful.

Council Action: It is recommended by the Council that the report of the Dental—Nurse—Pharmacy Committee be accepted as presented to the Council with the observation that there is a difference between owning and dispensing your own drugs.

Industrial Medicine Committee—George B. Sanders, M.D., Louisville, Chairman

Since no matter has been brought before this committee during 1960 or 1961, no special meetings of the committee were called and no business has been transacted by the committee.

Council Action: It is recommended that the report of the Industrial Medicine Committee be accepted as filed by the committee chairman.

Infant and Maternal Mortality Committee—William H. Parker, M.D., Owensboro, Chairman

The committee on Infant and Maternal Mortality of the Kentucky State Medical Association has held two meetings so far this year and will have a third meeting some time during the KSMA Annual Meeting in September. It is planned to have a complete statistical review of the work done by the committee since the beginning of our study some five or six years ago. We also plan to have a panel discussion with the presentation of perhaps two cases. The number of deaths reported thus far for the year 1961 is 23.

At our meeting in March we invited Mr. Gaines Davis, our legal counsel, to speak to us on the legal aspects relative to privileged communications. Although Mr. Davis was of the opinion that we were relatively safe without such a statute, he advised that it would perhaps be an added safeguard against possible litigation. The committee voted to proceed with whatever necessary to get the desired legislation enacted. The chairman then appointed a committee of Louisville doctors to contact the Council on Allied Professions and Related Groups and to ask that the Council communicate with the Board of Trustees. It was brought out that there were some other groups planning some special legislation and perhaps all of the desired legislation could be combined in one bill.

I should also like to point out that the chairman of our committee and Doctor Helen Fraser and Doctor Robert McLeod attended a Southeastern Assembly at Atlanta, Georgia in February. This was a most helpful and enlightening meeting. There were several representatives from the AMA, all of whom contributed materially to our knowledge about our common objectives. Some of our members also attended the session on Infant and Maternal Mortality study at the American College in Miami in April. This, too, was a revelation and encouraged us greatly in the pursuit of our own problems.

Our greatest problem is getting enough factual information to make our study seem realistic. While most doctors are cooperative in giving information, when contacted, it is most difficult under our present system to find more than a few men who are willing to sacrifice the necessary time to make adequate personal contact. Questionnaires are being sent to all doctors who have had a maternal death but the information obtained in this way is *almost* never adequate. It is the feeling of your chairman that we will never be able to garner the type of information we need until some one is designated by the Kentucky State Medical Association or the State Board of Health on a paid basis to gather this information as soon after a death has occurred as possible. This is our weakest link, our greatest need and I urge that steps be taken as soon as possible to implement this need.

Our second greatest need is an informed profession. Doctors throughout the state should be made to know that this is *not* a policing action and that all of us sooner or later will be confronted with the hazards of maternal death and our greatest aspirations and hopes are that there will be fewer and fewer maternal deaths in the state of Kentucky. We feel that the maternal death rate is not at an irreducible minus and that this objective can only be reached by the combined help and cooperation of all of us. We feel that the profession can and will be informed, but it will take time and patience. We can help locally by man to man conversation and through our local Medical Societies and can, in a broader sense, be helped through our State Medical Meetings and through our State Journal.

It is apparent from our study thus far that the profession can further reduce our maternal mortality rate and it is our solemn duty to use every means at our command to do so. We have also observed that the greatest number of maternal deaths occur in the para 7 or over groups and in those patients 36 years of age and over. It is therefore our duty as Obstetricians to see that such knowledge and information is disseminated to our patients and the community. So the patient herself will help us to avoid the hazards of high parity and of those who are approaching the menopause.

Council Action: It is the recommendation of this Council that the report of the Infant and Maternal Mortality Committee be accepted as presented by the chairman and that the matter of privileged communications be referred by the Board of Trustees to the Council on Legislative Activities for its consideration. We would also recognize that this committee is performing an important function and that the wishes of this committee should be given special consideration.

Physical Medicine and Rehabilitation Committee—Kenton D. Leatherman, M.D., Louisville, Chairman

This committee has not met during the year and there has been no activity of enough importance to warrant the meeting of all members of the committee.

A letter from a physician in Lexington concerning the problem of adequate rehabilitation services to workers who have been injured and are left with impairment was referred to this committee from the KSMA Headquarters Office. All members of the committee have received copies of this letter but to date no action has been taken by the committee other than holding it under consideration for future discussion.

Council Action: It is the recommendation of the Council that the report of the committee on Physical Medicine and Rehabilitation be accepted as presented.

Tuberculosis Committee—Richard E. Mardis, M.D., Louisville, Chairman

The Tuberculosis Committee feels that tuberculosis in Kentucky is a very serious problem, inasmuch as only the state of Arizona has a higher tuberculosis mortality rate than Kentucky. At the present time the Kentucky mortality rate is approximately twice that of the national average and there were 1200 new cases in 1960 in Kentucky. Partly due to this pressing problem in Kentucky, a statewide Conference was held in Lexington on May 3-5, 1961, which was called the "First Kentucky Tuberculosis Conference." Approximately 25 persons, all experienced in the field of tuberculosis, were present and this group made a report on their findings and recommendations as concerns tuberculosis.

It is the thinking of the Tuberculosis Committee that this report covers the field and area very well and that, rather than working up a separate report, the findings of this Conference in Lexington should be presented to the KSMA House of Delegates for their endorsement. It was noted by the committee that the report of the Tuberculosis Committee to the House of Delegates at the 1960 session was not adopted and we feel that this was due to the seventh recommendation of the committee, which called for endorsing a plan of making available, without cost to the patient, anti-tuberculous drugs, particularly isoniazid and PAS, for the long term therapy of tuberculosis. Actually, this recommendation was referring only to medically indigent patients and not to all patients.

The Tuberculosis Committee of the Kentucky State Medical Association would, therefore, recommend that the following report be accepted and endorsed by the KSMA House of Delegates:

FIRST KENTUCKY TUBERCULOSIS CONFERENCE RECOMMENDATIONS PREAMBLE

Tuberculosis has long been and is now a primary health problem in Kentucky. Few other states have suffered the ravages of this disease in a greater extent.

By use of methods and techniques now at hand, the control of the tuberculosis problem in Kentucky within this decade is now possible.

Through the discovery and development of now unknown, but more effective, methods and techniques, the eradication of tuberculosis may well be possible. With this hope, we set as our ultimate goal the complete eradication of tuberculosis in Kentucky.

Imaginative but practical planning, followed by bold and decisive action, will insure the attainment of this goal. Such planning and action should be both intermediate and long-range in nature, sufficiently flexible to permit immediate adoption or adaption to the hoped-for and anticipated improved methods and techniques as they may become available.

In the light of existing approved methods and techniques, the following methods are urged for immediate implementation.

I. TREATMENT

UNTIL AN EFFECTIVE VACCINE IS FOUND, ADEQUATE TREATMENT MUST BE CONSIDERED THE BEST MEANS OF CONQUERING TUBERCULOSIS.

GOAL: It is recommended that all known cases of tuberculosis be placed under effective treatment with provision for the continuity of comprehensive medical care from the time of detection to complete rehabilitation.

Therefore, the Conference recommends that emphasis be placed on the following points:

(1) Initial hospitalization of tuberculosis patients to insure adequate diagnosis, determination of appropriate treatment and education of the patient to his disease and treatment program.

(2) With current treatment methods, shorter hospitalization can be anticipated and earlier discharge encouraged provided the cooperative patient can be selected and adequate follow-up care can be insured.

(3) Clinically suspicious tuberculosis on X-ray examination, despite negative cultures for the tubercle bacilli, should be treated if the tuberculin skin test is positive and such conditions as cancer, pneumonia and fungus disease have been ruled out. Persons known to have tuberculin conversion may and children under six with positive tuberculosis should have antituberculous chemotherapy.

(4) If, despite all persuasive measures, an infectious tuberculosis patient refuses hospitalization, the patient should be isolated as a public health measure. Unless such isolation can be effected in the community, these recalcitrant patients should be referred to tuberculosis detention wards. It is expected that only the rare infectious or contagious tuberculosis patient will fall into the latter category.

(5) In exceptional circumstances, when tuberculosis patients cannot be hospitalized, diagnosis and treatment of the patient may be carried out on an ambulatory basis provided that an adequate diagnostic and treatment program can be instituted and maintained.

(6) Anti-tuberculosis chemotherapy should be supplied gratis to those medically indigent patients leaving the tuberculosis hospital prior to an acceptable medical discharge provided that the supervising hospital physician considers the patient a good candidate for treatment on a self-administration basis. However, such chemotherapy should only be continued when the physician in charge of the ambulatory treatment program concurs in the evaluation of this patient's fidelity to the prescribed treatment.

II. CASE DETECTION

IF MODERN TREATMENT IS TO WIPE OUT TUBERCULOSIS IN KENTUCKY, IT IS APPARENT THAT EVERY UNKNOWN CASE MUST FIRST BE FOUND.

GOAL: It was agreed that the case detection program should be intensified until every single undetected case of tuberculosis is identified.

Therefore, the Conference recommends the following:

(1) Examination of all known contacts.

(2) It was recommended that all hospitals in the State of Kentucky establish a tuberculosis screening program which would include a 14 x 17 chest film or a 70 mm. chest film on all admissions over the age of 14 and tuberculin skin testing be done on all children under the age of 14.

(3) A concentration of screening surveys with special emphasis on high-incident groups.

(4) Mandatory tuberculosis case detection examinations which include tuberculin skin testing and appropriate X-ray examinations should be required for admission to public schools, for recipients of welfare help, institutionalized individuals, and recipients of care for the medically indigent.

(5) Provide additional nursing personnel or special staff to do tuberculosis follow-up work. Such per-

sonnel would work out of the tuberculosis hospital in each hospital district.

(6) Provision of free tuberculin testing materials to private physicians throughout the State in order to facilitate their use and to increase the awareness of the private physicians of tuberculosis.

(7) Encourage private physicians to submit sputums on more of their patients by providing sputum containers for their use, to be sent to the State Department of Health for examination.

(8) Several methods for increasing the complete reporting of tuberculosis were suggested. They include:

(A) All positive smears and cultures for tuberculosis which are performed in private hospitals or laboratories should be reported to the Health Department.

(B) All patients with tuberculosis treated by private physicians should be reported to the Public Health Officer.

(C) Autopsied cases with evidence of active tuberculosis should be reported to the Health Department.

(D) Medical record room librarians should report all new cases of tuberculosis diagnosed in the hospital to the Health Department.

(9) The follow-up of patients must be improved and it was recommended that this might be accomplished by obtaining additional personnel such as a professional practical field worker.

III. EDUCATION

EDUCATION IS THE KEY FOR THE DETECTION OF AND PLACING UNDER TREATMENT EVERY EXISTING CASE OF TUBERCULOSIS AND INSURING THAT COMPLETE FACILITIES AND SERVICES FOR THE CONTROL OF TUBERCULOSIS ARE PROVIDED.

GOAL: To intensify and make use of all known methods specifically designed to reach the particular group of people approached.

Therefore, the Conference recommends the following:

(1) Education of the patient, his family, and the community about tuberculosis. This should make use of methods specifically designed to reach the particular group of people approached.

(2) The active encouragement and promotion of school health education.

(3) The active encouragement and promotion of public responsibility for the support of social and educational services aimed at the elimination of tuberculosis.

(4) The development of an outline of treatment to be published in professional journals.

IV. TRAINING

THE SUCCESS OR FAILURE OF THE CONCENTRATED ATTACK UPON TUBERCULOSIS WILL DEPEND UPON THE SKILLS AND KNOWLEDGE POSSESSED BY THOSE DEALING WITH THE PROBLEM.

GOAL: To provide an opportunity for the learning of the most modern techniques, procedures, and concepts in the diagnosis, treatment and rehabilitation of the tuberculosis patient.

Therefore, the Conference recommends the following:

(1) That there be a personnel-training program dealing with the problem of tuberculosis. This program should include workers in public and private agencies rendering assistance to the individuals and families, such Divisions as: The Division of Economic Security, Department of Welfare, Child Welfare, and family services agencies.

(2) A new position for public health personnel be established. These sub-professional workers would provide the assistance needed to carry out the intensive diagnostic, treatment, and educational program which the physicians and nurses are directing at the individuals, families, and communities. These sub-professional workers could be recruited from the local community and trained specifically for public health nursing activities at the level of a practical nurse. Such ancillary health workers could be trained to undertake tuberculin testing, immunizations, health education work, follow-up investigations of patients and families on home TB care, and other routine duties associated with public health work.

(3) One aspect of vocational training for hospitalized tuberculosis patients should include job training for laboratory X-ray, health education, and the ancillary field (public) health work. These trainees would be invaluable in increasing the "human resources" needed to intensify the attack on tuberculosis.

(4) Post graduate programs in the treatment of tuberculosis should be provided for physicians and other professional health personnel.

V. SOCIO-PSYCHOLOGICAL

THE LACK OF SOCIO-PSYCHOLOGICAL KNOWLEDGE PRESENTS A MAJOR GAP IN THE PRESENT TUBERCULOSIS CONTROL PROBLEM IN KENTUCKY.

GOAL: To provide the solution of obtaining the cooperation of individuals and families in case detection programs and the appropriate treatment when tuberculosis is found.

Therefore, the Conference recommends the following:

(1) All available knowledge of a socio-psychological nature in tuberculosis control should be collected and evaluated for application to the all-out attack on TB.

(2) Research should be encouraged and supported to obtain more information on the behavioral aspects of the patients, families, and communities to TB illness and medical care.

VI. ECONOMIC PROBLEMS

MENTAL ANXIETY CREATED BY THE LACK OF MATERIAL NECESSITIES OF LIFE FOR THE PATIENT'S FAMILY HAS LONG BEEN RECOGNIZED AS A DETRIMENT TO SUCCESSFUL TREATMENT OF THE PATIENT.

GOAL: To provide immediate help to the patient which would include the essentials of living for the patient's family.

Therefore, the Conference recommends the following:

(1) Broaden economic assistance programs to include those patients without children.

(2) Provide increased financial assistance for TB patients' families.

(3) Work to establish an "Emergency Disaster Fund" to free the "breadwinner" TB patient from financial worry, to give him peace-of-mind from knowing his family is being provided for.

VII. REHABILITATION

REHABILITION IS RECOGNIZED TO BE AN INTEGRAL PART OF COMPREHENSIVE MEDICAL TREATMENT AND IS ESSENTIAL IN THE TUBERCULOSIS PATIENT'S TOTAL RECOVERY.

GOAL: To provide rehabilitation services from the time of detection to the return of the patient to gainful employment.

Therefore, the Conference recommends the following:

(1) Patients be oriented regarding their disease from the time they are admitted to the hospital.

(2) To make available to TB patients counseling and evaluation services.

(3) The patient be referred for rehabilitation

services, if necessary, before he leaves the hospital.

(4) To maintain a close liaison between the TB hospital and the rehabilitation counselor.

(5) To develop more in-hospital training for TB patients by cooperative projects.

(6) Special research and demonstration projects for the rehabilitation of TB patients should be developed in cooperation with the Bureau of Rehabilitation Services and federal grants for this purpose requested.

(7) Facilities be made available for pulmonary function tests to determine rehabilitation potential of TB patients.

(8) There is great need for more rehabilitation services for TB patients in Kentucky. Therefore, immediate attempts should be made to have Congress change the federal distribution formula for federal rehabilitation funds which at present is very inequitable to Kentucky. We also recommend additional appropriations for rehabilitation at the next session of the State Legislature.

VIII. COORDINATION OF ATTACK

As in the conduct of any war, the committee believes in comprehensive strategy which recognized long-range planning and strengthening of positions as well as short-range and immediate action. Extending the analogy of war a step further, the committee became acutely aware of the number of agencies and organizations responsible for activity in tuberculosis control and feels strongly the need of one central authority which will be responsible for coordination of attack.

IX. FINANCING AND UTILIZATION OF ALL RESOURCES

ADEQUATE FINANCING IS VITAL TO AN ALL-OUT ATTACK ON TUBERCULOSIS.

GOAL: To insure adequate financing of all aspects of the tuberculosis control program in Kentucky.

Therefore, the Conference recommends that money be made available for the following purposes:

(1) To establish and maintain new facilities.

(2) To enlarge and extend present facilities.

(3) To adequately compensate presently employed skilled and professional personnel in order to retain their services.

(4) To recruit and train additional skilled and professional personnel needed.

(5) To establish emergency funds that will be available for the immediate relief of indigent patients and their families.

(6) To initiate and sustain additional medical and social research in those areas of greatest concern.

It is recommended that the following avenues of obtaining additional financing be diligently pursued:

(1) To encourage, to the fullest extent, sufficient state appropriations to match all federal monies available to have to do with an effective tuberculosis control program.

(2) To encourage increased federal and state appropriations in those areas of program, where the presently matched appropriations are not sufficient to meet the problem.

(3) To encourage and solicit special pilot and demonstrative projects from federal agencies and national organizations which are primarily concerned with tuberculosis control in the United States. Special projects and studies should be justified because of the intensity and scope of Kentucky's tuberculosis problem.

(4) To encourage larger voluntary contributions from legacies, bequests, and industry.

(5) To encourage and solicit continued financial support from the general public, civic, and benevolent organizations.

X. CONTINUATION OF THE CAMPELL HOUSE CONFERENCE

The Campbell House Conference should be made a permanent institution as an integral part of the Kentucky Tuberculosis Association program, charged with the specific responsibility to maintain a constant study and evaluation of the recommended course of action, incorporating into it all newly discovered and developed methods and techniques including vaccines and discarding uneffective and out-dated procedures.

Only upon attainment of the ultimate goal, should this Conference be dissolved and terminated.

CONCLUSION

With full awareness of and a deep concern for the seriousness of the tuberculosis problem as it now exists in Kentucky, with the confidence born of the effectiveness of our presently available methods and techniques, and with fervent hope for many new and even more effective methods and techniques, including an effective vaccine, these recommendations are respectfully submitted.

Council Action: It is recommended by the Council that this very fine and comprehensive report be accepted by the Council and that it also be endorsed by the Kentucky State Medical Association. We note that Doctor Mardis participated in this Conference at Lexington and we commend him and his committee for this very excellent report.

Voluntary Health Committee—Ralph M. Denham, M.D., Louisville, Chairman

This committee has met one time during the associational year and it has as its primary purpose the idea of stimulating physician interest in Voluntary Health Agencies and to also stress the importance of physician participation with the various groups.

After sending a letter to 15 national and county health organizations in Kentucky, we received 11 replies from the groups thanking the committee for their letter and, in both instances, the Medical Advisory Committee of the groups was listed. This letter informed the various groups that the KSMA does have such a committee and that it stands ready to assist them in any way possible at any time.

At the meeting of the committee and after considerable discussion it was the opinion of the committee that this committee should be disbanded inasmuch as there is apparently no useful purpose to be served by its existence at the present time. It was noted that this committee has been in existence for three or four years and insofar as is known there has been no problem presented to this committee for clarification or assistance. It is suggested that any problem in this area could possibly be handled by the Council on Allied Professions and Related Groups rather than having a special committee to serve in this area, and we would therefore recommend to the Council that this committee be disbanded for the present time.

Council Action: It is the recommendation of the Council on Allied Professions and Related Groups that, in accordance with the thinking of the Voluntary Health Committee, this committee be disbanded for the present time and if there are any problems arising in this area that the Council on Allied Professions and Related Groups would be glad to handle any matter which would previously have been referred to this committee.

In closing and as chairman of the Council on Allied Professions and Related Groups, I would like to take this opportunity to thank the members of the Council that have given of their time during this associational year in furthering the work of this Council.

I would also like to commend the committees for their activities and to express my appreciation to them for their assistance in the work that they have undertaken during the associational year.

Council on Allied Professions and Related Groups
Henry B. Asman, M.D., Louisville
Howell J. Davis, M.D., Owensboro
Ralph Denham, M.D., Louisville

W. Vernon Lee, M.D., Covington
J. Farra VanMeter, M.D., Lexington, Chairman

Recommendations by the KSMA Board of Trustees

The foregoing report is forwarded to the House of Delegates with the recommendation that the Council's report and the report of each of its committees be approved and implemented.

Recommendations, Reference Committee No. 4

Report of Council on Allied Professions and Related Groups—No. 15

The committees included in this Council's report are:

Blood Banks
Dental-Nurse-Pharmacy
Industrial Medicine
Infant and Maternal Mortality
Tuberculosis
Physical Medicine and Rehabilitation
Voluntary Health Groups

Blood Banks Committee

The committee noted the activities of the Blood Banks Committee and concurs in its statements.

Mr. Speaker, I move the adoption of this section of the report. Motion seconded and carried.

Dental-Nurse-Pharmacy Committee

This report was carefully studied and that portion that had to do with the ethics of physicians dispensing drugs was carefully noted.

Mr. Speaker, I move that this section of the report be approved. Motion seconded and carried.

Industrial Medicine Committee

This committee did not meet as no business was referred to it.

Mr. Speaker, I move the adoption of this section of the report. Motion seconded and carried.

Infant and Maternal Mortality Committee

Part of this committee's report was referred to another reference committee. However, our committee carefully studied the remainder of it and would like to call your attention to the two problems of obtaining factual information and the need for an informed profession on its activities. We would like to compliment this committee on its good work.

Mr. Speaker, I move the adoption of this section of the report. Motion seconded and carried.

Physical Medicine and Rehabilitation Committee

In this report it was noted that the committee had not met this year.

Mr. Speaker, I move the acceptance of this section of the report. Motion was seconded and carried.

Tuberculosis Committee

Mr. Speaker, this committee studied with great interest the report of the Tuberculosis Committee. Careful attention was given to its contents. It is the feeling of Reference Committee No. 4, regarding the first Kentucky TB Conference, that there are many suggestions which should be studied further and this section of Report 15 be referred to the Board of Trustees for further deliberation and study.

Mr. Speaker, I move the acceptance of this section of the report. Motion seconded and carried.

Voluntary Health Committee

The Reference Committee has studied this committee's report and notes that it recommends that the committee be disbanded. It was indicated that the committee had been in existence three or four years and insofar as is known, no problems had been presented to it for clarification or assistance. It was felt that any problems in this area could be handled by the Council itself.

Mr. Speaker, I move the adoption and implementation of this section of the report. Motion seconded and carried.

Report of Representative on State T. B. Coordinating Council

During the past twelve months there has been one meeting of the Kentucky State Coordinating Council for the control of tuberculosis. This was held September 13, 1960 at the offices of the Kentucky Tuberculosis Association. The following items were considered:

(1) Locked facilities for recalcitrant tuberculosis patients. It was pointed out that at present there are 20 locked ward beds at Hazelwood as compared to a total of about 850 hospital beds under the Tuberculosis Commission for the entire state. The number of known recalcitrant tuberculosis cases was estimated at a little less than 500. A motion was made that this situation be studied further particularly in comparison with other states who had inforced treatment facilities, the thought being that more than the present number of locked facility beds (20) should be provided.

(2) Chemotherapy of tuberculosis in Kentucky. Dr. Dorothy Magallon reported on a study of the use of chemotherapy for active tuberculosis in Kentucky which indicated that chemotherapy was not helping a great number of tuberculosis patients simply because they were not getting it. The possibility and desirability of increasing the out patient tuberculosis chemotherapy program was discussed but no specific recommendation was made.

(3) Plans for a Kentucky Tuberculosis Conference patterned after the Arden House Conference were presented. This conference was sponsored by the Kentucky Tuberculosis Association with the cooperation of governmental and voluntary health organizations as well as educators, sociologists and other experts in related fields. (This conference, known as the First Tuberculosis Conference or the Campbell House Conference, was held at Lexington, Kentucky the 3rd, 4th and 5th of May 1961.)

(4) A motion that the coordinating council discuss the feasibility of combining the Tuberculosis Hospital Commission with that of the State Health Department was proposed by Dr. E. R. Gernert but was not acted on by the coordinating council.

R. E. Mardis, M.D., Representative on State T. B. Coordinating Council

Recommendations, Reference Committee No. 4

This committee read with interest the report of the State TB Coordinating Council for the past twelve months. The committee approves of the four points listed in this report.

Mr. Speaker, I move the adoption of this section of the report. Motion seconded and carried.

Report of KSMA Representatives on Kentucky Health Council

There has been only one meeting of this Committee and this was held April 27, 1961. At this meeting the members of the Committee were brought up-to-date on the development of the Kentucky Health Council and no action was deemed necessary.

Since the meeting in April there has been no specific action taken by the Kentucky Health Council, therefore, no action by this Committee has been required.

Douglas L. Atherton, M.D., Louisville
J. A. Bishop, M.D., Jeffersontown
Ralph C. Denham, M.D., Louisville
Hoyt D. Gardner, M.D., Louisville
J. Farra VanMeter, M.D., Lexington
Carl Cooper, Jr., M.D., Bedford, Chairman

Recommendations, Reference Committee No. 4

Mr. Speaker, it is noted that this committee represented the Association at the April 27, 1961 meeting of the Kentucky Health Council. Reference Commit-

tee No. 4 recommends that this committee continue its active interest in this Council and that it continue to keep the Association informed of its progress.

Mr. Speaker, I move the adoption of this section of the report. The motion was seconded and carried.

Mr. Speaker, I move the adoption of this report as amended as a whole. Motion was seconded and carried.

As chairman of Reference Committee No. 4, I would like to express my deep appreciation to the members of this committee for their interest and cooperation.

Reference Committee No. 4
David Thurman, M.D., Chairman
Harvey Chenault, M.D.
Maurice Kaufmann, M.D.
Charles F. Long, M.D.
George I. Uhde, M.D.

REFERENCE COMMITTEE NO. 5

N. K. Kirby, M.D., Chairman
Reports on Medical Service

Report of the Council on Medical Services

PREFACE

Chapter VII, Section 4, of the KSMA Bylaws as revised in 1960, relating to the reorganization of the committee structure, reads in part:

". . . Each standing committee and Council shall report annually, at least six weeks prior to the Annual Meeting, to the House of Delegates via the Board of Trustees respecting its activities during the year last past. These reports shall be transmitted without alteration or amendment, to the House of Delegates by the Board of Trustees at the Annual Meeting, with such comments or recommendations as the Board cares to make. . ."

The material in this report of the Council on Medical Services is presented in the following order:

1. Actions and recommendations by the Council which it undertook on its own initiative.
2. Reports of the committees of this Council with the Council recommendations following each committee report.
3. Recommendations by the KSMA Board of Trustees on the over-all contents at the conclusion of the report.

* * * * *

The Council on Medical Services has met three times during the year; January 19, 1961, May 18, 1961 and again on June 15, 1961. The first meeting of this Council was devoted primarily to a discussion of the activities of the various committees serving under this Council, which are the Insurance Committee, the Advisory Commission to Blue Shield, the Advisory Committee to Blue Cross, the Physicians Placement Committee, the Committee on Federal Medical Services and the Committee on Aging. In addition, the Indigent Medical Care program is under the Council on Medical Services. Plans were formulated at this meeting for activities of these various committees and the chairmen that were present of these committees gave reports on the past and future activities of each respective committee.

The next meeting on May 18 was the special called meeting and at this meeting the action taken by the KSMA Advisory Commission to Blue Shield in reference to the so called Indiana Plan was discussed and after hearing a report on this plan it was recommended by this Council to the Board of Trustees that the recommendations of the Advisory Commission to Blue Shield concerning the Indiana Plan be adopted by the Kentucky State Medical Association. Another item discussed at this meeting was the recommendations of the Advisory Commission to Blue Shield on the listing of fees on the Blue Shield claim form by all physicians, which had been adopted by the House of Delegates at the 1959 session and also again reaffirmed at the meeting in 1960.

Following a discussion on the many facets of this matter, the Council on Medical Services then recommended that all physicians in Kentucky support the action taken by the House of Delegates in this connection and that they list their regular fees on these Blue Shield claim forms.

At the June 15, 1961 meeting the Council listened to reports of various committee chairmen and the Council had as its guest at this meeting the various chairmen of these committees who do not serve as a member of the Council.

The 1960 House of Delegates had recommended that the Kentucky State Medical Association give further attention and study to the need of a benevolent fund for its members and that this question should be referred to the new Council on Medical Services for survey and disposition as it sees fit.

The Council on Medical Services at the present time has no recommendations to make in this matter inasmuch as it would like further time to pursue this matter and it is the intention of our Council to contact each member of the Board of Trustees and to determine from them if there is a need for a fund of this sort as evidenced by the knowledge of the physicians in their respective Trustee District.

Our Council has also kept abreast of HR 10, which is a bill in Congress that would tend to give the self employed individuals, such as physicians, a more equitable tax treatment in setting up pensions and retirement plans for their later years. Briefly, HR 10, as it would concern a physician, would permit the physican to set aside each year a sum not to exceed the amount of $2500 each year for retirement purposes and this amount, which would be so deferred, would not be subject to any federal income tax at the time of setting it up in a qualified trust plan. This legislation, which has been introduced for a number of years, has, at the time of this report, passed the House over-whelmingly and has been referred on to the Senate. As in the past, our Council again recommends that the Kentucky State Medical Association support HR 10 and that our Kentucky senators be contacted and asked to lend their support to this bill if and when it is presented on the floor of the Senate for a vote. It is felt by the Council that it would be of no avail to contact our representatives, inasmuch as the measure has already passed in the House.

Doctor Simpson reported on the Indigent Care program and said that both the PA and MAA plans were started on January 1, 1961 under rather adverse circumstances. The Governor's Advisory Council was unable to complete the studies and recommendations concerning the mechanics and scope of the program until December 28, 1960, just three days before it became operational. Most of the difficulties arose from the fact that there were so many clients and a relatively small appropriation to cover the cost of services. Because of a low budget-patient load ratio it was necessary to place rather severe restriction on services with a limitation of the services to (1) the acutely ill and injured, (2) three days of hospitalization, (3) drugs (only available to PA recipients) were limited to a formulary—compiled by a sub-committee whose director is Dr. C. C. Sparks, past president of the KSMA and also chairman of the KSMA Technical Advisory Committee to the Governor's Council—and also limited to use of generic drug names as an economy factor. Dental services available only to PA recipients were also limited. Physicians' services were limited to house and office calls and were idemnified at $3.00 and $2.00 respectively. No provisions were initially made for nursing or nursing home services.

All of these limits and restrictions were considered temporary and were to be adjusted at the end of the first quarter of 1961. Since there were no readily

available actuarial data by which the index of usage of the services per capita could be calculated, the plan was too drastically restricted as was indicated by usage data compiled by a study of the program's activity. On June 1 the following changes were made:

1. Compensation for six day's hospitalization, but for acute illnesses and injuries only.
2. The drug list is currently being revised. Also, MAA recipients were approved for drugs.
3. Liberalization of dental services and MAA clients have been included.
4. Physicians' services still limited to home and office calls, but including all illnesses, and the indemnity raised to $5.00 and $3.00 respectively.

There have been many growing pains, most of which can be attributed to the vastness and complexity of the program which involves more than 140,000 PA clients and an estimated 87,000 MAA clients, none of whom were familiar with the provisions and restrictions of the program. Other factors were an equally unschooled staff in both the administrative and contracting state agency as well as an unprepared group of vendors.

There were difficulties in securing proper invoice forms for vendor services and in securing a pocket list of approved drugs with trade and generic names listed to facilitate prescribing in this cumbersome but economical manner.

As clients and vendors have become more familiar with the mechanics of the program, its usage is increasing rather rapidly. The operational rules and regulations will be changed to reflect usage and other actuarial data compiled from the plan's experience. Much remains to be done but those who have been actively engaged in an attempt to make the plan workable feel that, with continued effort on the part of the administrative agencies, and patience and forebearance on the part of the clients and vendor groups, a large number of those Kentuckians who have no resources can be provided adequate medical care without an undue burden upon the taxpayer.

Submitted below are the reports of the various committees serving under the Council for the year, which are as follows:

KSMA Insurance Committee, John G. Dickinson, M.D., Glasgow, Chairman

The Insurance Committee has met once during the associational year and a considerable portion of its time was devoted to a study of the situation at Albany, Kentucky on alleged abuse and over-utilization of hospital stay involving payments from Blue Shield-Blue Cross. It is the opinion of the Insurance Committee that this matter should be referred on to the KSMA Board of Trustees to discipline any physician responsible for unprofessional conduct and a recommendation was made to the KSMA Board of Trustees at their April 27, 1961 meeting that this matter should be more fully explored by the Board of Trustees. This Committee was also interested in the matter of privileged communications but inasmuch as two other committees within the framework of the KSMA had already devoted quite a bit of time and study to this matter, this committee took no action concerning any legislation other than sending the statement of opinion by the Insurance Committee to the KSMA Hospital Committee for their information.

Another matter that this Committee has been quite interested in is the provision in the Kentucky revised statutes that permits a municipality to tax companies selling health insurance. This statute has not been adhered to, however, there has recently been formed a Kentucky Municipal League. This League is now attempting to have Blue Shield and Blue Cross pay a tax on the premiums that they collect from the citizens in Kentucky. It is the feeling of the Insurance Committee that this is an unjust tax because it is levied on people who are trying to prepay their medical bills under a prepayment plan. We feel that this will defeat the very purpose of prepaying our voluntary health insurance and that the KSMA should undertake to have legislation of this sort repealed.

The Insurance Committee has also been approached by a representative from the Commonwealth Life Insurance Company asking the KSMA to endorse a simplified insurance claim form which has been approved by the Health Insurance Council of America. It is the feeling of the Insurance Committee that the simplified claim form that the KSMA had previously adopted is a very good form and that prior to endorsement of this form further study be given to this matter and that the KSMA Headquarters Office be asked to write a letter to the Department of Insurance in Frankfort and seek their opinion on the form approved by the Health Insurance Council and to take no action until the Insurance Commissioner in Frankfort has been contacted.

The Insurance Committee is still interested in some policies that are sold by companies that are inadequate and we are presently studying reports from other states to see if we should endorse legislation which would require certain standard provisions of health and accident policies to be outlined on the outside cover of each policy. This study has not yet been completed and no recommendation is being made at the present time on this matter.

Council Action: It is the recommendation of the Council that the report as presented by the Insurance Committee be accepted by the KSMA and that this Council specifically recommend to the Board of Trustees that the Kentucky State Medical Association support legislation which would amend the present statute so that health insurance plans would be exempt from municipal taxation on insurance premiums.

Advisory Commission to Blue Shield, Vinson Pierce, M.D., Covington, Chairman

The KSMA Advisory Commission to Blue Shield has met three times since the last annual report was submitted to the House of Delegates of the Kentucky State Medical Association.

The discussions at these meetings have been largely concerned with three objectives. The first of these was to find ways for improving the relationship between the physicians of our State and our Blue Shield Plan.

The second objective was to promote a better understanding on the part of physicians and of subscribers of the problems and accomplishments of Kentucky Physicians Mutual.

The third, and perhaps the most important objective, was to consider, and to pass on to the Board of Directors of our Blue Shield Plan, such suggestions as might lead to better coverage for the subscribers to our plan.

Three of the suggestions for improving plan-physician relationships, and for helping physicians and subscribers to understand the problems and aims of Blue Shield, have been approved by the plan and have been put into operation.

One of these, which has been followed by the plan for the past few years, and which has been mentioned in previous reports, is that of having members of the Blue Shield staff (together with members of the Board of Directors, whenever possible) appear at one or more meetings of county medical societies each year to discuss various problems with the society members. In the past two years almost fifty of the county medical societies have availed themselves of the opportunity of having such a program presented to them.

Another suggestion made by our Commission was that of having our plan publish a Kentucky Blue Shield Newsletter at such intervals as should be deemed advisable. The first of these Newsletters was recently published, and was favorably received by our physicians.

The third suggestion required approval of both the Blue Shield Plan, and by the Editorial Board of the Kentucky State Medical Journal. Such approval was readily granted by both parties. The suggestion was that a Question and Answer Page, relating to Blue

Shield problems, should appear monthly in the Journal of the KSMA. The June issue of the Journal contained the first of these pages. It is hoped that this will prove to be an effective and interesting method for clearing up any misunderstandings which might exist concerning the operation of our Blue Shield Plan.

In regard to improving and expanding Blue Shield coverage, there were two major suggestions which the KSMA Advisory Commission to Blue Shield has made this year.

One of these was in regard to a special type of indemnity plan developed by the Indiana Blue Shield a few years ago. Under this program each County Medical Society is given an opportunity to consider the following features of the new plan:

1. That the Society adopt the "Preferred" Blue Shield schedule of indemnities, which offers very realistic indemnities.
2. That in each County Society which wishes to adopt this program, the members agree by resolution to accept the schedule of indemnities as full payment to those Blue Shield subscribers who are hourly rated employees within the groups who enter into this program; provided, however, that no physician shall be bound by these fees if, prior to rendering the service, he has notified the subscriber that an additional charge will be made.
3. That at all times the physician shall be willing to discuss fees with his patients.

The above program has been in effect in twenty-two counties in Indiana for some time and has worked to the satisfaction of physicians and subscribers alike.

The Advisory Commission to Blue Shield has recommended to the Board of Directors of Kentucky Physicians Mutual that the Board authorize the adoption of a plan similar to the above; provided that approval be first given by the Board of Trustees of the KSMA.

Many physicians in our State, (including all of the Directors of our Blue Shield Plan) along with many of the subscribers to our Plan, have long felt that there is need for new and expanded Blue Shield Coverage, beyond that which has heretofore been offered by our Plan.

At the request of the Advisory Commission to Blue Shield the staff of Kentucky Physicians Mutual has prepared four new programs for consideration by the Board of Directors of the Plan.

These are

(1) Increased "in-hospital" medical benefits
(2) Payment for home and office visits (with a deductible feature)
(3) Extended benefits
(4) Major medical coverage

The programs are to be offered on a "group" basis only, with specified premium rates, on a "rider" basis, for each type of coverage.

The Board of Directors of Kentucky Physicians Mutual, Inc. after careful consideration of these new programs, has approved each of them. These will soon be offered to those groups who are interested in making the new coverage available to their members.

The members of the KSMA Advisory Commission to Blue Shield are all in agreement in believing that the success of the voluntary prepayment mechanism (especially of the Blue Shield plans) is essential to the continuation of the "fee for service," "free choice of physician" type of medical practice. They also believe that the only way in which governmental control of medical practice can be prevented is for the voluntary prepayment plans to survive and prosper.

For these reasons, and because without the prepayment mechanisms the cost of medical care today is beyond the reach of many of our people, we urge that every physician do all within his power to support our Plan.

Suggestions from any member of our State Association, concerning ways in which our Blue Shield Plan may be improved, will be welcomed and considered by the Advisory Commission.

The members of the Advisory Commission wish to express their sincere appreciation to the Board of Directors and to the Staff of Kentucky Physicians Mutual for the helpfulness and cooperation which these have manifested at all times. Our Blue Shield plan has considered every suggestion made by the Advisory Commission, and has attempted to carry out each such suggestion of the Commission which was approved and sanctioned by the KSMA.

Council Action: It is the recommendation of the Council that the report of the Advisory Commission to Blue Shield be accepted and, as stated earlier in this report, it is the recommendation of this Council to the Board of Trustees that the so called Indiana Plan be implemented in Kentucky.

Advisory Committee to Blue Cross, Sam A. Overstreet, M.D., Louisville, Chairman

There has been no meeting of the Advisory Committee to Blue Cross since the last Annual Meeting of the Kentucky State Medical Association. It has been my effort to keep in contact with miscellaneous problems and, as chairman, act for the committee. From time to time there is an accumulation of hospital cases that need some clarification or advice and I have met with Mr. John Watkins of the Blue Shield-Blue Cross staff at about monthly intervals, at which time these cases have been reviewed and some advice has been offered as to their disposition. This activity is regarded as a temporary expedient since no other members of the Advisory Committee are readily available to act for the committee as a whole.

The annual meeting of the Advisory Committee will be held at the time of the State Association Annual Meeting in Louisville.

Council Action: It is recommended by the Council that the report of the Advisory Committee to Blue Cross be accepted as presented by the committee.

Physicians Placement Committee, Delmas M. Clardy, M.D., Hopkinsville, Chairman

The Physicians Placement Committee has met once during the year on May 4, 1961 in conjunction with the Rural Kentucky Medical Scholarship Fund meeting.

This committee was formed with the idea of helping provide better medical care, furnishing the people with physicians, if possible, and also assisting physician who desire to locate. It is the policy of the Placement Service never to recommend a doctor or a community and it only serves as a liaison to bring the two together to work out the details themselves. The Service started out running down all information about places that wanted physicians to move or locate in their community and since that time this committee has had a lot of assistance from the Sears Foundation. The Physicians Placement Service in the past had gone along in a slow manner because of a lack of staff and after Mr. Grogan joined the staff of KSMA, he was assigned to this service and he has been very active in setting up new procedures and improving on some of the old procedure.

When correspondence is received from physicians looking for locations, a questionnaire is sent to them which they are asked to complete and return to the KSMA Headquarters Office and their name is then added to the placement listing, which is distributed to doctors looking for associates or for additional doctors for a community. This list is revised periodically in order that it may be kept up to date.

Council Action: The Council recommends that the report of this committee be accepted and that the Physicians Placement Committee be commended for their good work.

Committee on Federal Medical Services, O. Leon Higdon, M.D., Paducah, Chairman

The Committee on Federal Medical Services has

not met yet this year because it has not been found necessary that a committee meeting be held, either on the Veterans medical affairs or on the Medicare program.

Members of the committee have been circularized by a letter for opinions on minor problems and, as you know from reading the KSMA Journal, questions have been asked of the membership throughout the year. Secretaries of the County Medical Societies have been directed to write to the Committee regarding any problem concerning either the Hometown Veterans program or the dependent Medicare program. No specific complaints have been received by this committee. The Veterans Hometown Medical Care Program contract has been renewed after recommending to this Council that inasmuch as no specific complaints have been received that the contract continue as in the past and that the Medicare Program also apparently is satisfactory to the membership.

The chairman of the committee attended a Veterans Forum at Indianapolis last year and it was the opinion of the chairman that the program was well organized and would certainly have been of benefit if more physicians had been able to attend. This Conference pointed out that until 1924 Veterans Hospitals had 26,000 beds and today there are 125,000 beds. The present Federal law states that "To the extent that beds are available, Veterans with Non-Service disabilities may be cared for under the program." We would have no wish to deny adequate care for a Service-connected disability, however, more and more new Veterans Hospitals are being constructed while others are being closed. This Program or Forum at Indianapolis pointed up specifically:

1. The need for co-ordination between the Federal government; the Veterans organizations, and the Community organizations in planning for hospital beds.
2. Further study and implementation of the home town care of Veterans which the American Medical Association has always endorsed and repeatedly suggested usage thereof.
3. That the Federal government once and for all, accept the full responsibility for defining its responsibility for the care of the disabled Veteran. It is obvious that the present law has undergone much variance since its institution and that the abuses are increasing. Today, a much higher percentage of the American citizen's tax money is needlessly being spent on the Veterans Medical-Dental Program.

It is the recommendation that this committee again go on record and recommend to the House of Delegates of the KSMA that our delegates to the AMA be instructed to renew their plans for a "new look" at the Veterans Program and that appropriate correspondence with out National Congressmen be authorized.

Serving under the committee on Federal Medical Services is the Medicare Review Committee and this committee had no formal meeting during the year. However, the Medicare Review Committee has been active and they have reviewed approximately 120 special report Medicare cases during the ten months from July 1, 1960 to May 1, 1961 and appropriate action was taken on each of these cases.

Council Action: It is recommended that the report of the Committee on Federal Medical Services be accepted, along with that of the Medicare Review Committee.

Aging Committee, Earl P. Oliver, M.D., Scottsville, Chairman

The KSMA Committee on Aging met once during the associational year and had as guests Reverend H. Dix Archer, Chairman of the Citizens Commission on Aging, the President-Elect of the American Geriatrics Society, A. Clayton McCarty, M.D., Louisville and Mr. Avil McKinney, A Blue Shield-Blue Cross representative.

With medical care for the aged still commanding a large share of the spotlight on the national legislative scene, it is the opinion of this committee that in keeping with American traditions it is first the primary responsibility of the individual in providing for his medical care as well as other personal care.

When the individual is unable to provide this care for himself, the responsibility should rightfully pass to his family, then to the local community, county, and the state, all in that order. Then, and only then should the federal government assume a role, and then only in cooperation with the other governmental bodies heretofore cited.

In this connection our committee also endorses the Kerr-Mills program in Kentucky and it is our opinion that all physicians in Kentucky should solidly unite behind this program and actively participate in order to make this program do the most good for those that are needy and eligible under the program. We see no merit in the argument of those who decry about the "Means Test" in this legislation. Without some sort of restriction or "means test" the program could become unmanageable. All of us in our everyday living are confronted with different types of means test and this test is vital in determining who needs help and it came into being as a method of saving the people's taxes for use where they were most needed.

Additionally, our committee recommends to the Council on Medical Services that:

1. The KSMA give firm backing and support to the Citizens Commission on Aging, and we would specifically recommend that the KSMA endorse any proposed legislation in the 1962 General Assembly that would tend to establish this Commission as a permanent body under statutory regulations.
2. We again reaffirm our position that the KSMA work with the Kentucky Association of Nursing Homes in ways to improve quantity and quality of these facilities. This would make available less expensive hospital type care for the less seriously ill aged citizens and leave more beds available for the acutely ill.
3. The KSMA and County Medical Societies encourage the establishment of chronic and convalescent care units in connection with new and existing hospitals.
4. We as physicians speak up on the issue of freedom of medical practice and freedom in all walks of life in preference to socialistic programs, which would be more expensive and less effective and that we as physicians ask our patients to express their views to their congressmen and senators.
5. The KSMA and its component societies devote more study to nurse recruitment in an effort to alleviate the shortage of registered nurses in Kentucky.
6. County medical societies take the leadership in well adult conferences on aging and institute educational programs for elderly persons on the importance of:
   a. Periodic health examinations and preventive medicine.
   b. Accident prevention education.
   c. Proper nutrition in maintenance of good health.
7. That we again reaffirm our opposition to compulsory retirement at age 65, but rather it be based on ability to perform, etc. We should encourage the younger segment of our population to begin in their youth to prepare themselves for old age and retirement.
8. The KSMA Advisory Commission to Blue Shield and the Blue Shield-Blue Cross staff be commended for its efforts and study in again offering to those over 65 an opportunity to purchase coverage on hospitalization and medical care. We would recommend that this open period of enrollment be fully publicized so that all in Kentucky may know of this

offering and that a News Release be prepared by the KSMA on this enrollment period noting that over 70,000 people in Kentucky over age 65 are now covered. We would also encourage the commercials to provide low cost insurance for the aged. We feel this to be another positive step in the health care of the aged.

9. The KSMA explore the possibility of preparing a a pamphlet which could serve as a buyer's guide to those over 65 as well as those under 65 purchasing voluntary health insurance. Inasmuch as the KSMA Insurance Committee has been very active in discussing good comprehensive coverage and misrepresentation, we ask that this matter be referred to the Insurance Committee for further study.

Council Action: It is recommended by the Council that the report of the Aging Committee be accepted and that the recommendations that have been presented by the committee be adopted by the KSMA.

The chairman of the Council on Medical Services would like to commend the committees, their chairmen, and the committee members, along with those who have served on the Council on Medical Services in the first year's activity of this Council under our new organizational set-up. The Chairman feels that there are many items contained in this report which deserve the careful and undivided attention of the KSMA and its members in the fulfillment and implementation of some of these programs.

Council on Medical Services
John Dickinson, M.D., Glasgow
W. Vinson Pierce, M.D., Fort Thomas
Earl P. Oliver, M.D., Scottsville
Sam A. Overstreet, M.D., Louisville
Claude C. Waldrop, M.D. Williamstown Chm.

Recommendations by the KSMA Board of Trustees

The foregoing report is forwarded to the House of Delegates with the recommendation that the Council's report and the report of each of its committees be approved and implemented with the following exception:

The Board of Trustees neither approves nor disapproves the recommendation of the Advisory Commission to Blue Shield that the so-called "Indiana Plan" be implemented in Kentucky.

Recommendations, Reference Committee No. 5

Report No. 13—Council on Medical Services

Mr. Speaker, Reference Committee No. 5 has studied Report No. 13 of the Council on Medical Services. Our Reference Committee disagrees with the paragraph in the report dealing with the listing of fees on Blue Shield Forms. It is the feeling of this committee that the KSMA House of Delegates should reverse their decision regarding the listing of fees.

This committee concurs with the part of the report which deals with the establishment of the benevolent fund for membership of KSMA and we urge further study by the Council to set up such a benevolent fund if further study indicates a need be present.

The KSMA Insurance Committee

The Reference Committee No. 5 accepts the recommendations made by the KSMA Insurance Committee. We feel that they are adequate.

Advisory Commission to Blue Shield

Reference Committee No.5 has reviewed the report of the KSMA Advisory Commission to Blue Shield. After lengthy and full discussion offered by interested members appearing before this committee on the matter of the Indiana Plan for Blue Shield, and after thorough consideration in Executive Session this committee takes exception to this report and recommends that the KSMA House of Delegates reject and oppose the Indiana Plan.

After a lengthy discussion, the following amendment to the recommendation of Reference Committee No. 5 relating to the report of the Advisory Commission to Blue Shield was offered: "That the entire second sentence be deleted and the following inserted in its place 'The House of Delegates of KSMA agrees that each county medical society may decide for itself whether or not to adopt the Indiana Plan or some similar plan of pre-payment health care.'" It was moved, seconded and carried that the amendment be accepted.

Advisory Committee to Blue Cross

The report of the Advisory Committee to Blue Cross was reviewed by Reference Committee No. 5 and was accepted in its entirety.

Physicians Placement Committee

The report of the Physicians Placement Committee was reviewed in its entirety by Reference Committee No. 5 and we recommend that this report be accepted and wish to commend members of this committee for their good work.

Committee on Federal Medical Services

The report on Federal Medical Services was given the wholehearted endorsement and approval by Reference Committee No. 5.

Mr. Speaker, we move the adoption of this report No. 13 as amended as a whole with the exceptions listed by this committee in its report. The motion was seconded and carried.

Council on Communications and Public Service—Portion dealing with listing of fees for Blue Shield.

The 1960 House of Delegates did again reaffirm the recommendation of the KSMA Advisory Commission to Blue Shield that physicians list the charge made by them for the service rendered to a patient, when filling out the Blue Shield claim form. The Executive Committee of the KSMA Board of Trustees, at the October 20, 1960 meeting, referred this matter on to this Council for implementation.

Our Council has discussed this matter on two occasions and it was the unanimous opinion of all those present at both meetings that they were opposed to listing such fees for the following reasons:

1. Since this is an indemnity plan, it is our belief that there is no useful purpose to be served by listing such charges.
2. This would tend to standardize fees without individualizing services rendered.
3. In essence such a listing of fees might be used in the establishment of a relative value scale, which has been opposed by the Kentucky State Medical Association.

This Council, therefore, recommends to the KSMA Board of Trustees and the House of Delegates that it reconsider its action taken at the 1959 and 1960 Annual Meetings on the listing of these fees by the members of this organization.

Recommendations, Reference Committee No. 5

The excerpt of Report 14 dealing with the listing of fees for Blue Shield was accepted and approved.

Mr. Speaker, I move the adoption of this section of the report. The motion was seconded and carried.

Report of the Board of Directors of Kentucky Physicians Mutual, Inc.

The Board of Directors of Kentucky Physicians Mutual, Inc. presents its annual report to the Kentucky State Medical Association. It reflects the twelfth year of operation and service to the people and physicians in Kentucky.

As of August 31, 1961, 722,482 people were members of the Plan, reflecting an increase of 33,398 people over the membership one year ago. During the 12-month period ending June 30, 1961, $6,566,000

was paid to physicians. This is an increase of $1,096,000 over the previous 12-month period. It is estimated that for the calendar year 1961 payment to physicians will exceed $7,000,000.

The cost of operation for the 12 months ending June 30, 1961 was 9.87% of income, a reduction of almost 1% over the previous year. It is interesting to note that of the 74 Blue Shield Plans in this country only 6 operated at less administrative cost per member than the Kentucky Plan.

After considerable study the KSMA Advisory Commission to Blue Shield recommended that Kentucky Physicians Mutual offer aditional endorsements to provide broader coverage to subscribers. Accordingly, Kentucky Physicians Mutual adopted and is now offering the following new endorsements:

1. In-Hospital Medical Care
   Provides higher indemnities for medical cases beginning with the first day of hospitalization.
2. Home and Office Calls
   Provides indemnity allowances beginning with the third visit for each illness and the first visit for each accident for office calls and physicians' home calls.
3. Anaesthesia
   Provides an indemnity equal to 20% of the surgical allowance in the Preferred Schedule.
4. Extended Benefits
   This endorsement is written jointly with Blue Cross providing hospital and other benefits for 730 days. Allowances are made for office calls, home calls, additional allowances for surgery and psychiatric care. Coverage is extended to nursing homes and for certain other out of hospital services.
5. Major Medical
   This endorsement is also written jointly with Blue Cross and provides a payment of 80% of all covered medical expenses over and above the basic Blue Cross-Blue Shield benefits and a cash deductible.

In addition to the development of new coverages Kentucky Physicians Mutual is currently contacting all members urging them to upgrade their coverage to the Preferred Plan with better endorsements for in-hospital medical, anaesthesia and X-ray.

To help meet the health needs of the elderly, Kentucky Physicians Mutual and Blue Cross will conduct an open enrollment period October 15th to 30th whereby any Kentucky resident, regardless of age or employment, may apply for coverage. Applications will be underwritten to protect the financial stability of the Plan.

There is an urgent need for uniformity of benefits between the various Blue Shield Plans in order to enroll and hold large national accounts. Much progress has been made in this regard within the last year, and a professional services index has just been formulated by a committee of professionals appointed by the National Association.

Much credit for the expanded benefits offerings must be given to the KSMA Advisory Commission so ably led by its Chairman, Dr. Vinson Pierce. Dr. Pierce, during the year, has been appointed as one of the three AMA members on a national joint commission composed of representatives of the AMA, American Hospital Association, Blue Shield and Blue Cross. Purpose of this commission is to promote closer liaison and unity between these four bodies and formulate national policy for the benefit of the American people.

In closing I want to express my deep appreciation to the members of the Board, my fellow officers, all of our KSMA members who have cooperated so well and the splendid Blue Cross-Blue Shield staff, whose efforts have made this one of the most successful years in our history.

John Dickinson, M.D.
President

Recommendations, Reference Committee No. 5

Mr. Speaker, Reference Committee No. 5 has reviewed the report of the Board of Directors of the Kentucky Physicians Mutual and we feel the report is a good one, but, we, as a committee, would recommend that the Board of Directors of the Kentucky Physicians Mutual consider the inclusion of coverage of diagnostic procedures on a broader basis for "out patients" in order to eliminate unnecessary hospitalization.

Mr. Speaker, I move the adoption of this report with the inclusion of the recommendation made by this committee. Motion seconded and carried.

Report of the Rural Kentucky Medical Scholarship Fund

With the passing of each year the Rural Kentucky Medical Scholarship Fund gets larger and larger in many different ways. 1. More students add to the total number of recipients in medical schools and those taking internships. 2. More recipients complete medical training and enter rural practice to pay off their moral obligation. 3. The total amount of money to operate the program increases by several thousand dollars each year.

When medical school registration is completed this fall, 223 different students will have received loans from the Fund since it started back in 1946. Twenty-three students will receive loans for the first time this year and this will make a total of 99 recipients now in medical schools or taking internships.

The major purpose for which the Scholarship Fund was started some fifteen years ago is now paying big dividends. Approximately 76 physicians we assisted are practicing in rural Kentucky areas. Well over half of this number have completed their moral obligation —that is one year of practice for each loan received— and are continuing in rural practice.

In addition to the $140,000 raised at the inception of the program from donations by physicians, lay people, and civic organizations, the State Legislature and the last three Governors have appropriated another $160,000 to make a total of $300,000 to be used in the loan and scholarship program. Governor Combs supplemented the $50,000 biennium appropriation by the 1960 Legislature with an additional $15,000 from his Emergency Fund. For the 1962-63 biennium the trustees of the scholarship fund are asking the Legislature to appropriate $70,000. This amount is needed because more and more students are requesting loans each year. The opening of the University of Kentucky Medical School has almost doubled the number of requests for loans.

The Board of Trustees of the Scholarship Fund had its annual meeting on May 4, 1961. There are twenty-six members on the Board of Trustees and practically all of them attended the meeting. At this meeting the following individuals were elected to serve as trustees for the first time: Professor Meredith Cox, Richmond; Claude E. Cummins, M.D., Maysville; O. Leon Higdon, M.D., Paducah; Mr. Allan Trout, Frankfort.

On August 3, 1961 the Executive Committee of the Board of Trustees met and accepted six late applicants that had requested loans, in addition to taking care of routine business.

Four recipients of the program are now practicing in critical counties and for this they have, or are in the process of having their loans cancelled one for each year they remain in practice in one of the critical counties. The trustees at the May 4 meeting removed Knox County from the critical county list and replaced it with Wolfe County. The ten most critical counties are now Breathitt, Elliott, Jackson, Knott, Leslie,

Magoffin, Martin, Owsley, Powell and Wolfe.

Again the Board of Trustees of the Rural Kentucky Medical Scholarship Fund expressed deep appreciation to the Honorable Bert T. Combs and the senators and representatives of the 1960 Legislature. Governor Combs has had many nice comments for the Scholarship Fund and to prove that they were all sincere he has backed them up by appropriating money from his Emergency Fund. For this we are all grateful.

Rural Kentucky Medical Scholarship Fund
C. C. Howard, M.D., Glasgow
Chairman, Board of Trustees

Recommendations, Reference Committee No. 5

Mr. Speaker, Reference Committee No. 5 has studied the report of the Rural Medical Scholarship Fund. We feel that this program offers much to rural Kentucky and feel that this program should be given our wholehearted support.

Mr. Speaker, I move the adoption of this report as a whole. The motion was seconded and carried.

Report of Kentucky Advisory Committee to Selective Service

During the early part of this fiscal year this committee had very little work to do numerically, but there were several controversial matters up for consideration which demanded a good deal of time. Unfortunately, one case was settled by political decision in Washington—an action which has never been countenanced in the eleven years of this committee's activities. Since two of our Hill Burton hospitals in small Kentucky communities were benefited by this unusual action, no serious protest was made.

One more matter came up in June which might need explanation. Even before the Berlin situation brought on a demand for more physicians for military service, voluntary enlistments of doctors did not keep up with requirements. As a result, some men were called up by conscription, and many thought the Kentucky quota was a little large. The truth of the matter was this, however—many of the physicians on this list, while registered with Kentucky boards, are now located in many other states. Their call up, therefore will not reduce the number of physicians *in Kentucky* by any appreciable amount.

A new National Advisory Committee has been selected (Dr. Elmer Hess, Chairman, died during 1961, necessitating changes), and it is anticipated that renewed activity will not take place in the conscription of physicians. Meanwhile, the Reserves will be tapped, which is the usual procedure when emergencies arise.

The committee would like to thank again Mr. Joseph Sanford and his office associates for continued and invaluable aid; also district and local committees for their help. We continue to have the most satisfactory and cordial relations with Washington and Frankfort Selective Service facilities. The committee chairman would like to recognize all committee help, but especially the vice chairman, J. Duffy Hancock, M.D., who has carried on while the chairman has been out of the State from time to time.

Advisory Committee to Selective Service
Sydney G. Dyer, M.D., La Center
J. Duffy Hancock, M.D., Louisville
Charles B. Billington, M.D., Paducah
O. B. Coomer, D.D.S., Louisville
F. E. Hull, D.V.M., Lexington
Frank W. Jordon, D.D.S., Louisville
Lula B. McClain, R.N., Louisville
Sam A. Overstreet, M.D., Louisville
Marcus Randall, D.D.S., Louisville
L. O. Toomey, M.D., Bowling Green
Russell E. Teague, M.D., Frankfort
Glenn U. Dorroh, M.D., Lexington
A. Clayton McCarty, M.D., Louisville,
Chairman

Recommendations, Reference Committee No. 5

The report of the Advisory Committee to Selective Service was reviewed by Reference Committee No. 5 and we as a committee have no comments to make on this report.

Mr. Speaker, I move the adoption of this report as a whole. Motion was seconded and carried.

Resolution A
Fayette County Medical Society

"WHEREAS, the Advisory Commission of the Kentucky State Medical Association to Blue Shield has recommended adoption of the "Indiana Plan" of Blue Shield by the Kentucky State Medical Association; and

WHEREAS, spokesmen of industry (labor and management) are seeking special consideration from a selected insurance carrier for a contract for complete insurance coverage with fixed fee schedule for specified services; and

WHEREAS, from every indication, Blue Shield at the national level is making every effort to promote service type coverage in each state, using the Physicians' Mutual as an instrument of leverage for bargaining purposes; and

WHEREAS, such "Trojan Horse" technique introduces a third party with its implied dictatorial powers thereby encroaching upon time honored freedom in the practice of medicine; and

WHEREAS, the Fayette County Medical Society after reasonable deliberation and discussion has gone on record by circularizing all practicing physicians in Kentucky its objection to any plan which violates the Patient-Doctor relationship; and

WHEREAS, the great majority of practicing physicians in Kentucky have thus far withstood the threat of third party interference in the practice of Medicine; and

WHEREAS, any plan such as the "Indiana Plan" is discriminatory to private commercial insurance carriers who also are opposed to any system which interfers with fair competition, and thereby are in empathy with the fundamental principle of free enterprise;

BE IT RESOLVED: That the Kentucky State Medical Association House of Delegates vigorously reject and oppose the adoption of the so-called "Indiana Plan" of the Blue Shield or any similar plan of insurance which tends to foster third party regulation of Medical fees by the Kentucky Physicians Mutual, Incorporated."

Mr. Speaker, I move the adoption of Resolution A.

At this point, a delegate from the Fayette County Medical Society withdrew the above resolution, in view of the action taken on the Indiana Plan.

Resolution G
Daviess County Medical Society

Mr. Speaker, Reference Committee No. 5 has reviewed the following resolution:

"RESOLUTION BY THE DAVIESS COUNTY MEDICAL SOCIETY TO BE PRESENTED BEFORE THE ANNUAL KENTUCKY STATE MEDICAL ASSOCIATION MEETING IN SEPTEMBER 1961.

Whereas, Resolution A before the Kentucky State Medical Association submitted by the Fayette County Medical Society opposes the so-called Indiana Plan which is fee-for-service arrangements between the individual county medical societies and Blue Shield of Indiana—called the Pay-All Plan by Indiana physicians.

Whereas, copies of the resolution have been circulated by the Fayette County Medical Society to all

member county societies in the Kentucky State Medicas Association.

And, whereas, the members of the Daviess County Medical Society have studied this resolution and the various aspects of the Indiana Blue Shield Plan and have counselled with members of the Indiana medical societies which have been affected by this plan in their state. The Daviess County Medical Society requests that it be therefore resolved that Resolution A be supported by the House of Delegates to the Kentucky State Medical Association."

Mr. Speaker, I move the adoption of Resolution G.

The delegates from Daviess County Medical Society withdrew the preceding motion at this point, in light of the action taken by the House on the Indiana Plan.

Resolution E
Campbell-Kenton County Medical Society

Mr. Speaker, Reference Committee No. 5 has reviewed the following resolution:

"Introduced by: Campbell-Kenton County Medical Society

Subject: Status of Kentucky State Indigent Care Program

This program had a stormy birth and is still experiencing considerable growth pain. It was felt that good progress is being made; that a sincere effort to iron out inequities is being put forth. Feeling that this program may well be our most effective answer to the "King Bill" type of legislation, we feel the program deserves our support. However, it was recommended that a continuing re-evaluation of the program go on, and that inequities be eliminated as rapidly as possible.

Mr. Speaker, I move the adoption of Resolution E. The motion was seconded and carried.

Resolution H
Daviess County Medical Society

Mr. Speaker, Reference Committee No. 5 has reviewed the following:

"Daviess County Medical Society September 14, 1961 Owensboro, Kentucky

Be it resolved that the Daviess County Medical Society accepts in principle the Kentucky Medical Care Program based on the Kerr-Mills Bill, a state to state plan for providing medical care for the needy, aged and the medically indigent. This society trusts that the administrators of the Kentucky Medical Care program will continue to make necessary changes as the program evolves as they have in the past.

Be it resolved that the Daviess County Medical Society feels that there is unnecessary limitation of services and that these services should be expanded to cover realistically the needs of the medically indigent as allowed and covered by the Kerr-Mills Bill. This society feels that unnecessary hospital utilization would be reduced if services such as out patient laboratory and x-ray studies as well as more extensive diagnostic office procedures were covered by this program.

Be it resolved that the Daviess County Medical Society feels that all fees should be commensurate with services and that all services should be adequately compensated within the abilities of the program. This Society feels that hospital care, surgery, anaesthesia, laboratory and pathology fees and x-rays as well as house and office calls should be compensable.

Be it resolved that the Daviess County Medical Society urges most strongly that the Kentucky State Medical Society Committee to work with the administrators of the Kentucky Medical Care Program in an advisory capacity should be a special separate committee of interested delegates from the several county societies.

Mr. Speaker, we move the adoption of Resolution H. The motion was seconded and carried.

Mr. Speaker, we move the adoption of this report, as amended, as a whole with the exceptions listed by this committee in its report. Motion was seconded and carried.

Mr. Speaker, I wish to thank the members of this committee for their assistance in preparing this report.

Reference Committee No. 5
N. Lewis Bosworth, M.D.
J. C. Salato, M.D.
John Willard, M.D.
B. F. Radmacher, M.D.
N. K. Kirby, M.D., Chairman

REFERENCE COMMITTEE NO. 6

N. I. Handelman, M.D., Chairman
Reports on Constitution and Bylaws; Special Committees

Report of KSMA Advisory Committee to the Editor

Your Committee has had a relatively uneventful year. The Committee was asked to pass on the advisability of including as a regular department in The Journal a question and answer page on Blue Shield matters. The Committee unanimously endorsed this recommendation which was made by the KSMA Advisory Commission to Blue Shield.

Edmund D. Pellegrino, M.D., professor and chairman of the Department of Medicine, University of Kentucky College of Medicine, served as symposium issue editor of the 1960 Journal of KSMA and has his material all ready for publication in the October 1961 issue.

Your committee understands that the Regional Medical Editors Conference held last October in Lexington attracted approximately 65 people from 27 states and the District of Columbia.

To our editor, Sam A. Overstreet, M.D., and our associate editor, George W. Pedigo, M.D., we want to express our deep appreciation for your splendid efforts and leadership in developing a continually improving Journal.

Advisory Comittee to the Editor
George F. Brockman, M.D.
Robert L. Houston, M.D.
Blaine Lewis, M.D.
Francis Massie, M.D.
James E. Hix, M.D., Chairman

Recommendations, Reference Committee No. 6

This Committee was asked to pass on the advisability of including, as a regular department of the Journal, a question and answer page on Blue Shield matters. The Committee unanimously endorsed this recommendation which was made by the K.S.M.A. Advisory Commission to Blue Shield.

The Committee noted that Doctor Edmund D. Pellegrino, who served as Symposium Issue Editor of the 1960 Journal of K.S.M.A. had his material all ready for publication in the October 1961 issue. The Committee noted that the Regional Medical Editors Conference held last October in Lexington attracted approximately 65 people from 27 states and the District of Columbia.

To our Editor, Sam A. Overstreet, M.D., and Associate Editor, George Pedigo, M.D., the Committee expressed their deep appreciation for the splendid efforts and leadership in developing a continually improving Journal.

Our Committee further wished to express its intense admiration and appreciation to all those associated with the Journal for the outstanding work that they are doing.

Mr. Speaker, I move the adoption and acceptance of this section of the report. Motion was seconded and carried.

Report of the Professional Relations Committee

Because the Professional Relations Committee had no matters of any type referred to it this year, it has no report to make to the House of Delegates.

With the establishment of grievance committees in the larger medical societies and with the activating of trustee district grievance committees throughout the state, to date, it appears that all grievances have been successfully handled either at the county or district level.

Professional Relations Committee
Richard R. Slucher, M.D., Buechel
Edward B. Mersch, M.D., Covington
Robert W. Robertson, M.D., Paducah
Irvin Abell, Jr., M.D., Louisville
Clyde C. Sparks, M.D., Ashland,
Chairman

Recommendations, Reference Committee No. 6

Because the Professional Relations Committee had no matters referred to it during the year, it had no report to make to the House of Delegates. Our Committee wished to note the manner in which these problems are handled and we quote from the 1960 Constitution and Bylaws of K.S.M.A., revised September 21, 1960, paragraph 2, Sestion 9, Chapter VIII.

"All grievances whether handled by individual Trustees or by District Grievance Committees, shall be reported to the Professional Relations Committee, which shall include in its report to the Board of Trustees a statistical resume of the number of cases handled and the disposition thereof. In addition, the Professional Relations Committee shall make recommendations to the Board of Trustees with respect to any course of action which the Committee determines to be desirable in the light of its experience during the year covered by its report."

Mr. Speaker, I move the adoption and acceptance of this section of the report. Motion was seconded and carried.

Report of the KSMA Committee on Third Party Medicine

The Third Party Committee has had two meetings this year. On both occasions it considered the two items passed on to us by the 1960 KSMA House of Delegates—They are: 1. What constitutes ethical salaried employment of physicians. 2. Consider the possibility of sponsoring a professional practice act. In addition to these two items considerable time and thought has been given to sponsoring legislation giving us a well-defined law on corporate practice.

What Constitutes Ethical Salaried Employment

Section 4, 5 and 6 of the AMA Principles of Medical Ethics were used as a guide in consideration of what constitutes ethical salaried employment. The following rules were evolved:

1. The medical services of a physician may ethically be granted or otherwise dispensed only in conformity with libertarian principles and the law.

2. Because the practice of medicine by a corporation or any other unlicensed person is unlawful, a physician may not be employed on a salary by a corporation which, in turn, purveys his services to the general public and pockets the fees earned by him.

3. A physician may be employed on a salary by a corporation or other business to fill the medical needs of its stockholders, officers and employees, where no fee is collected by it from the physician's patients.

4. A physician may not be employed under any arrangement which would subject the free exercise of his medical judgment to supervision or review by any lay person.

5. A physician may be employed under any financial arrangement satisfactory to him (including a salary) which does not amount to exploitation, by any person or group of persons, to attend to their personal medical needs and the medical needs of their families.

6. A physician may not be employed by any person, firm, association, or corporation (on a salary or otherwise) which solicits patients for him or which publishes materials extolling his skill, calling attention to honors bestowed upon him, or which otherwise advertises his professional qualifications and standing for the purpose of inducing the public to come to him for professional advice or treatment.

7. A physician should not permit himself to be employed under conditions which unduly impair the personal physician-patient relationship which is so important to the patient's sense of well-being and to maintenance of public affection and esteem for the medical profession. He should insist that his patient load be held to manageable levels, so that he can spend enough time with each patient to become acquainted with him and to give his medical problems careful and thorough attention.

8. A physician should not permit himself to be employed at a rate of compensation which is not comparable to the usual fees paid for the same kind of service by people in the same economic group in a given community, or which is so low as to make it virtually impossible for competent service to be rendered.

9. A physician should not permit himself to be employed by any third party mechanism which denies a reasonable degree of free choice of physicians, where other competent physicians are readily available.

Headquarters Office was asked to send these rules to Mr. Joe Stetler, Director of the AMA Law Department, for his comments. The following is a quote from Mr. Stetler—

"I do not believe that it is desirable for a medical society to adopt an ethical pronouncement governing compensation paid to a salaried physician who has entered into a legally valid contract of employment. The same applies to any ethical admonition which would prevent physicians from accepting employment by third party mechanisms where such employment is not contrary to the law of the jurisdiction.

"The opinions which I have expressed in this letter are my own and it is my recommendation that your Committee should be guided in their actions by the KSMA attorney who is more familiar with the laws of Kentucky and the local situation than I am."

Our Committee has not had a meeting since receiving the information from Mr. Stetler, therefore, we are sending both the Committee's views and Mr. Stetler's thinking on to you for your consideration.

Revising Medical Practice Act

The primary purpose for revising the Medical Practice Act would be to spell out just what the practice of medicine covers. It was felt that if the Act is revised it would be well to have some clarification of third party medicine. It is the general feeling that an attempt to revise the Medical Practice Act should not be made until a more propitious time. It was stated that if the medical profession feels it can pass this legislation it should be done, but if they feel they cannot, it would be better not to introduce it.

Corporate Practice

Considerable thought was given to the advisability of introducing legislation whereby professional groups may form corporations for tax exemption purposes.

Mr. Davis was asked to draw up a suggested statement pointing out the problems involved in setting up such professional corporations in order to obtain tax approved pension plans. He submitted the following:

"PROFESSIONAL CORPORATION SET DANGEROUS PRECEDENT"

KSMA's Committee on Third Party Medicine wishes the membership to be aware of certain undesirable "side effects" from the organization of so called "professional corporations" by physicians. The Committee is aware of a movement in certain other states to secure legislation which would permit the formation of corporations in which all of the capital stock would be held by licensed physicians, in order to enable those physicians to set up tax exempt pension plans for themselves and perhaps other employees of the corporation. By this device, physicians seek to obtain the advantages which have otherwise been denied them by Congress' persistent refusal to enact the Jenkins-Keogh Bill.

The difficulty with such a plan is that it puts physicians in the position of engaging in the "corporate practice of medicine" and weakens the position of courts, which like the Court of Appeals of Kentucky, have held that a corporation which employs licensed physicians and sells their services to the public, is engaged in the unlicensed practice of medicine.

Our Court reasons that a corporation cannot be licensed to practice medicine because it cannot be examined as to its knowledge or moral character, and that what it cannot do directly, it cannot do indirectly through the employment of licensed employees. Critics of this line of reasoning argue that the evils of corporate practice do not exist when the corporation is a non-profit corporation, since the physicians actually do the "practicing" and the element of possible exploitation is eliminated.

Our position, and the position generally of organized medicine has been that a non-profit corporation has no more character and can no more be examined as to its medical knowledge than one for profit, and that the existing rule should continue to apply. But if a corporation whose stockholders are physicians can practice medicine through employed licensed physicians, why not a non-profit, charitable, hospital corporation?

Your Committee urges the membership to think this one through, before jumping to any ill-considered conclusions as to the desirability of "professional corporations."

This statement was mailed to every doctor in Kentucky on the back of KSMA News Capsules.

KSMA Committee on Third Party Medicine
Winfrey P. Blackburn, M.D., Frankfort
Ballard Cassady, M.D., Pikeville
Daryl Harvey, M.D., Glasgow
Thomas McElhinney, M.D., Covington
John S. Harter, M.D., Louisville, Chairman

Recommendation of the KSMA Board of Trustees

At the time this report was given—7:30 p.m.—a quorum was no longer present. Members of the Board that were in attendance, however, felt that the report should be forwarded to the House of Delegates for its consideration and approval, as there were no exceptions from the members present.

Recommendations, Reference Committee No. 6

This Committee had two meetings during the year. On both occasions it considered the two items passed on to them by the 1960 K.S.M.A. House of Delegates. They were (1) what constitutes ethical salaried employment and (2) considering the possibility of sponsoring a professional practice act.

Nine rules were avowed using Section 4, 5 and 6 of the AMA Principles of Medical Ethics as a guide in consideration of what constitutes ethical salaried employment. These rules were sent to Mr. Joe Stetler, Director of the AMA Law Department, for his comments. The following is a quote from Mr. Stetler:

"I do not believe that it is desirable for a medical society to adopt an ethical pronouncement governing compensation paid to a salaried physician who has entered into a legally valid contract of employment. The same applies to any ethical admonition which would prevent physicians from accepting employment by third party mechanisms where such employment is not contrary to the law of the jurisdiction.

"The opinions which I have expressed in this letter are my own and it is my recommendation that your committee should be guided in their actions by the KSMA attorney who is more familiar with the laws of Kentucky and the local situation than I am."

The Committee has not had a meeting since receiving the information from Mr. Stetler and therefore made no recommendation.

Our committee, after much study and consultation with Mr. Gaines Davis, came to the conclusion that they would make no recommendations whatsoever.

Mr. Speaker, I move the adoption and acceptance of this section of the report. Motion was seconded and carried.

Report of the Committee to Study the Constitution and Bylaws

Your committee met once during the associational year and formulated its recommendations. At a meeting of the Board of Trustees on July 27, the report of the bylaws committee was read. Recommendation of the Board of Trustees on each item will be found immediately after the item.

Officers Conference (Interim Meeting)—The original purpose of the County Society Officers Conference, it was explained, was to indoctrinate the local county society officers in the mechanics of operating a county medical society. Eventually, however, it took up more and more socio-economic matters, etc. This created somewhat of a problem in that non-county society officer physicians did not attend the conference because they felt it was specifically for the officers. It was brought out that the conference is now felt to be very profitable to every physician in the state.

For this reason, it had been suggested that the committee consider changing the name of the conference. In the discussion, it was brought out that such a change might bring down the attendance of officers of county societies. It was recommended that the name "interim" be given to the conference in the future. This will be a recommendation of the Board of Trustees.

Terms of office, Secretary and Treasurer—At the July 28, 1960 meeting of the former Council, now the Board of Trustees, Woodford B. Troutman, M.D., secretary of the Association, had expressed the view that the five-year terms of the KSMA secretary and treasurer should be shortened to create uniformity. At the July 28 meeting, however, it was noted that nothing could be done at that time, since the secretary and treasurer had three more years of their present terms to serve. Consequently, Doctor Troutman moved that the matter be considered and studied at the next meeting of the bylaws committee and "changed accordingly." This motion had carried; and the committee was asked to consider the matter.

In the discussion that followed, it was pointed out that there are certain benefits in having experienced persons in these two important positions. It was felt that the length of these terms of office presented a certain continuity not had in the usual three-year terms. However, the committee also was of the opinion that the secretary and treasurer could serve for an indefinite period of time and could thus be re-elected any number of times. At the conclusion of this discussion, it was agreed that the committee recommend in its report to the House of Delegates that, taking effect in 1963, the terms of the Association's secretary and treasurer be shortened to three years.

The bylaws committee was asked to set up a procedure for the submitting of reports of councils and committees as prescribed by the bylaws revised in

1960, Chapter VII, Section 4, for use by the headquarters office. This was accomplished.

Quorum—The new bylaws state that five-member committees and councils shall have a quorum of three and that seven-member committees shall have a quorum of four. It was brought out that occasionally only two members of a committee are able to attend a meeting. This creates a problem, especially when those in attendance have traveled a long distance, because the bylaws state that no business can be taken up—other than that of setting another meeting date. The attorney was consulted on this point and it was his suggestion that a post card be set up for the committee members to state their willingness in appointing the chairman their proxy to vote in their place, if they could not attend the meeting. The view was expressed that this might be recommended as a policy to the Board of Trustees at its meeting on July 27 and it was agreed that this would be done.

At this time it was pointed out that a meeting of the Council on Scientific Assembly had been called for July 13. It was felt that this meeting was not necessary inasmuch as all details concerning the Annual Meeting had been completed. However, according to the bylaws, all councils must meet twice during the year. The members of the committee felt that in cases where the second meeting was not necessary it should not be necessary that one be held. It was agreed that the recommendation that this particular council meet only once a year in the future be made to the House of Delegates via the Board of Trustees on July 27.

Changing of KSMA's Name—It had been suggested that the word "state" in the KSMA's name might suggest to some people that the Association is affiliated with the State Government, and it was felt that it might be an advantage to change the Association's official name. After a discussion of this matter, however, it was decided that the name, "Kentucky State Medical Association" should be left as it is.

Consideration of Changing Clause in Bylaws Relating to Trustee District Meeting—It was noted that the bylaws provide that each trustee district have at least one meeting each year and that all of the districts had not been adhering to this ruling. It was felt that more drastic action against those who fail to schedule a meeting be taken or else that this particular portion of the bylaws be removed. After discussion, it was decided to recommend to the Board of Trustees that a committee be appointed to study the desirability of enforcing this ruling or taking it from the bylaws.

Committee to Study the Constitution and Bylaws
Harry Denham, M.D., Maysville
Robert C. Dyer, M.D., Louisville
Ernest C. Strode, M.D., Lexington
George H. Widener, M.D., Paducah
Cooley L. Combs, M.D., Hazard, Chairman

Recommendation of the KSMA Board of Trustees

The foregoing report is forwarded to the House of Delegates with the recommendation that it be approved and implemented with the following exceptions:

(1) Being of the opinion that the recommendation of the bylaws committee that the name of the Officers Conference be changed to Interim Meeting, should be approved and implemented without delay, the Board has ordered that this be done and no further action by the House is required.

(2) The Board feels that because such a policy might discourage committee attendance, the recommendation of the bylaws committee that committee chairmen be given a proxy for members of the committee who could not attend should not be approved at this time.

(3) The Board feels that because it might cause some of the districts who do have successful meetings to stop doing so, the recommendation of the bylaws committee that more drastic action be taken against those districts failing to schedule annual district meetings or that this particular portion of the bylaws be removed should not be approved.

Recommendations, Reference Committee No. 6

This committee met once during the associational year and formulated its recommendations. They recommended that the name of the Officers Conference be changed to Interim Meeting. This was approved and has been implemented by the KSMA Board of Trustees.

The Committee recommended that the terms of the Association's secretary and treasurer be shortened to three years.

The Committee set up a procedure for the submitting of reports of councils and committees as prescribed by the Bylaws as revised in 1960, Chapter VII, Section 4, for use by the headquarters office. This was accomplished.

The committee recommended to the Board of Trustees that a proxy system be set up in order to maintain a quorum when necessary for committees and councils. The Board of Trustees disapproved of this recommendation.

The Committee recommended that the Council on Scientific Assembly meet only once a year in the future.

The Committee discussed the changing of the KSMA name to Kentucky Medical Association, leaving out the word State, and they decided that this should be left as is. The Committee recommended to the Board of Trustees that a committee be appointed to study the desirability of enforcing the ruling that each Trustee District hold at least one meeting each year, or taking it from the Bylaws. The Board of Trustees did not approve of this recommendation.

Mr. Speaker, I recommend the adoption and implementation of this section of the report. Motion seconded and carried.

Report of County Society Officers Conference Committee

This committee has no report as the program for the 1960 conference had been planned before there was an opportunity to form the committee. The 1960 conference was set up under the supervision of the President.

KSMA County Society Officers Conference Committee
N. L. Bosworth, M.D., Lexington
Sam A. Overstreet, M.D., Louisville
J. M. Stevenson, M.D., Brooksville
Joseph H. Saunders, M.D., Lexington
Richard G. Elliott, M.D., Chairman

Recommendations, Reference Committee No. 6

This Committee has no report as the program for the 1960 Conference had been planned before there was an opportunity to form the committee. The 1960 Conference was set up under the supervision of the President.

Mr. Speaker, I move the adoption and acceptance of this section of the report. Motion seconded and carried.

Report of the Representative on Practical Nurses Training

Your representative was appointed December 5, 1960 to serve as KSMA's Representative on the Practical Nurses Advisory Committee.

As of this date, there have been no problems or activities necessitating a meeting of this committee.

Walter R. Johnson, M.D.

Representative on Practical Nurses Training

Recommendations, Reference Committee No. 6

Our representative, Walter Johnson, M.D., was appointed December 5, 1960 to serve as KSMA representative on the Practical Nurses Advisory Committee. There were no problems or activities necessitating a meeting of this committee.

Mr. Speaker, I move the adoption and acceptance of this section of the report. Motion seconded and carried.

Mr. Speaker, I move the adoption of this report as a whole. I wish to express my appreciation to each member of Reference Committee No. 6 for his profound interest in the business of this Committee. Motion seconded and carried.

Reference Committee No. 6
Austin Bloch, M.D., Louisville
Howard Frisbee, M.D., Stanford
C. J. Shipp, M.D., Greenville
E. C. Whitaker, M.D., Berea
N. I. Handelman, M.D., Louisville
Chairman

REFERENCE COMMITTEE NO. 7

Robert S. Tillett, M.D., Chairman
Miscellaneous Reports

Representative to Conference of Presidents and Other Officers of State Medical Associations

The meeting of the Conference of Presidents and Other Officers of State Medical Associations was held in the Grand Ballroom of the Statler-Hilton Hotel, New York on Sunday afternoon, June 25.

The program consisted of five excellent talks including one by Congressman Durward G. Hall from Missouri on the situation in Washington and another by Congressman Walter H. Judd of Minnesota on the medical missionary as a representative of American medicine. The main business considered at the business session was the election of officers for next year.

Several of our members and representatives of the Headquarters Staff attended with our delegate.

Richard G. Elliott, M.D.
Lexington, Representative

Recommendations, Reference Committee No. 7

The report of Doctor Richard G. Elliott, President of the Kentucky State Medical Association, was considered.

Mr. Speaker, I move the acceptance of this section of the report. Motion was seconded and carried.

Report of the Representative on the Advisory Committee to the U. of K. Student AMA Chapter

Following my recent appointment to this committee, it was necessary for me to be out of town when the University of Kentucky Chapter of the Student AMA was formed.

Our committee has not convened since then. As our enrollment grows and more classes are added, no doubt it will be necessary for our committee to meet more often.

We are looking forward to participating in this important work.

Richard H. Segnitz, M.D.
Representative on Advisory Committee to U. of K. Chapter, Student AMA

Recommendations, Reference Committee No. 7

This committee has not convened this year. Mr. Speaker, I move the acceptance of this section of the report. Motion was second and carried

Report of the Representative on the Advisory Committee to the U. of L. Student AMA Chapter

During the 1960-61 school year, we have again been in close contact with the University of Louisville Student AMA. Their annual National meeting was in Chicago, Illinois, in May of 1961, at which time, three members representing the University of Louisville were in attendance. Our annual budget allocation of funds to assist them in making this trip was again made available and used. In addition, two members from the University of Kentucky School of Medicine student body accompanied them as observers. Again, our student representatives took an active part; two of them holding important and strategic committee appointments and positions.

In order to facilitate and help in the organization of the Student AMA group at the University of Kentucky, one afternoon and evening was spent in Lexington with the student body and faculty and the Student AMA representative, liaison representative from the KSMA, Mr. Sanford. Representatives from our Student AMA were also present and detailed discussions were held in order to give assistance in the formation of this new unit. Dean William Willard is encouraging the continuing progress in the formation of the new student group from the University of Kentucky School of Medicine chapter.

In the future, a once a year liaison committee meeting is being planned between the two student groups in order to mutually help each other and for the exchange of ideas between the student bodies as a whole.

This year it has again been impressive to observe this student group in action. They are generally well aware of the major problems and crises that confront American Medicine and are strongly pushing in their efforts to help us in this apparently never ceasing struggle. At the annual convention of the American Medical Association, a check for $5,000 from the SAMA was turned over to the AMA as a supplementing factor to the Education and Hospital Section. This indicates that they are not only philosophically supporting us, but materially as well. They are to be strongly commended for assuming this type of leadership in an early stage of their medical careers.

Hoyt D. Gardner, M.D.
KSMA Advisor to the
University of Louisville
Student AMA Chapter.

Recommendations, Reference Committee No. 7

This Committee's report has been received by this Committee.

The Committee was particularly interested to note that the SAMA had contributed a check for $5000 to the Education and Hospital Section of the AMA and feel that this organization is to be highly commended.

Mr. Speaker, I move the adoption of this section of the report. Motion seconded and carried.

Report of the McDowell Home Committee

This committee has held two meetings—one in February and one in August, 1961. The committee notes with pride that the house and apothecary shop have been well kept up, that the grounds are neat and that painting and rewiring have been done on the property.

The committee also notes that Dr. Laman Gray (Committee member) obtained from the Fifth District of the American College of Obstetricians and Gynecologists a gift of $250.00 and from the American Gynecological Society a gift of $100.00; that Dr. Duffy Hancock obtained from the Southeastern Surgical

Congress a gift of $250.00; that Dr. Francis M. Massie obtained from the Southern Surgical Association a gift of $200.00 and from the Texas Surgical Society a gift of $200.00. This makes a total of $1,000.00. The committee notes and hereby calls attention to the fact that these gifts are not promised annually and are subject to renewal or refusal on annual solicitation by the committee.

The committee notes with some alarm that expenses for the year ending June 30, 1961 have been more than $700.00 in excess of the income in spite of the gifts detailed in the above paragraph. The financial statement shows that the fund now has a balance of a little more than $500.00 due to the fact that we entered the last fiscal year with more than $1,500.00 in reserve.

The committee has asked the State Medical Association that their annual appropriation of $1,500.00 be paid during the month of September because there are several outstanding bills to meet which add up to more than the amount in the bank.

The committee notes with great pleasure that the receipts from admissions to the McDowell Home have been more than $1,300.00. This is the largest sum collected from this source in any year since the house was opened for visitors.

The committee takes this occasion to thank Mrs. Waller O. Bullock for her gift of a silver coffee pot; to Mrs. Walker Owens for her constant interest and supervision; to Mr. George Grider (committee member) for his efficient conduct as local custodian of the property; to Dr. Earl Sloan (committee member) for the splendid work which he and his colleague, Dr. Francke, have done in restoring the apothecary shop drugs and in preparing small items for sale; to express our gratitude to our hostess, Miss Estelle Crawford, for the gracious way she has received the public.

This committee hereby recommends that the State Society increase the annual appropriation to $3,000.00. We remind the society that our main source of income is from the State Society, The Kentucky Surgical Society, admissions at the door, private gifts and contributions from the various surgical organizations and that this source of income is by no means stable. For this reason we are, therefore, recommending an annual appropriation from our State Society sufficient to insure the proper upkeep of the grounds and maintenance of the property.

McDowell Home Committee
Charles A. Vance, M.D., Co-Chairman
Irvin Abell, Jr., M.D.
Laman A. Gray, M.D.
O. Leon Higdon, M.D.
E. M. Howard, M.D.
David W. Kinnaird, M.D.
Dean Earl P. Sloan
Mr. George Grider
Mr. Sterling Coke
Francis M. Massie, M.D., Co-Chairman

Recommendations, Reference Committee No. 7

A review of the financial conditions and problems of the McDowell Home Foundation is contained in this report. It is noted that for the year ending June 1961 there was a $700 deficit, although this was made up from the reserves of the previous year. The Committee agrees that additional funds are necessary for the continuation of this project and recommends that the State Society increase the annual appropriations to $3000.

Mr. Speaker, I recommend the adoption and implementation of this report. Motion seconded and carried.

Report of the Medicolegal Administrator

The medicolegal administrator wishes to report that there has been no call for his services in the past year.

John D. Gordinier, M.D.
Medicolegal Administrator

Recommendations, Reference Committee No. 7

The Medicolegal Administrator reported that there had been no call for his services this year.

Mr. Speaker, I move the acceptance of this section of the report. Motion seconded and carried.

Report of the Building Committee

In a bold and progressive step, this House of Delegates one year ago authorized the purchase of land for the construction of a building to house the Association's executive and administrative activities. The final report of your committee is now being written in brick and mortar. This is an interim report and a discussion of some of the ideas that relate to the completion of the building.

The Committee met immediately following the adjournment of the House to draw up recommendations to the Board. On the following day, at its organizational meeting, the Board of Trustees of KSMA directed the purchase of the land, employment of architects and the handling of the many other details. It endorsed the Committee plan for construction at deliberate speed. A detailed schedule of the various steps for completion was projected at a meeting on October 13th, and it was found that sound orderly progress should make the building available for use by February, 1962.

A misunderstanding by the Zoning Commission with reference to our initial request for eligibility delayed land purchase for two months, until rezoning could be accomplished by ordinance. We were able to secure re-dedication of the street at the same time, however, to secure a considerable improvement in the property.

Firm specifications were given to the architect on January 25th, and, on April 5th, we were able to report to the Board that proposals for bids had been issued that day.

Bids were opened on April 20th, and the following proposals were received:

Otho Tapp and Son	$156,300.00
Garst-Receveur	155,422.00
Robert Struck and Son	154,400.00
Rostetter Construction Company	153,200.00
Ale Bornstein	153,148.00
Fred J. Lichtefeld	149,400.00

Two weeks of intensive bargaining by the low bidder, the Architect, and the Committee ultimately produced a rock-bottom bid of $133,635.30. With faith in the future of Kentucky medicine, and anticipating inflation, we advocated construction. The Executive Committee of the Board not only endorsed the contract, but instructed us to negotiate an offer on 160 feet of additional frontage for our lot, and instructed us to undertake further studies in supplemental financing. The full Board of Trustees endorsed these actions by directing the purchase of the two additional lots, despite a $1,000 increase in the price per lot in the nine months since the original option.

In a simple ground-breaking ceremony, Lt. Governor Wyatt graciously reviewed the outstanding history of this Association, and extended felicitations. Attendance and press coverage of a progressive step by the Association were unexpectedly good.

A summary of paid and projected costs, together with our appraisal of the financial position of the Association, and some suggestion for the handling of construction costs, were summarized for a meeting of the Trustees on July 28th. The Trustees authorized the Investments Committee of the Board to manage these details. (A format has been set up for providing the House with a detailed financial summary at the latest possible closing date prior to the assemblage of the House, in order that the Delegates may have the most current information for consideration.)

Supplemental Financing

In considering supplemental financing, we are re-

submitting a supplemental report which was submitted with our report last year. We have explored many other plans, but found only one other which seems desirable. Emmet F. Horine, M.D., Historian of the Association, in advising us with reference to the valuable historical properties of the Association, has indicated that additional facilities for display and preservations, as provided in the new building, may be expected to lead to additional acquisitions of historical souvenirs.

Recommendations

1. That construction proceed as planned, toward probable completion in January.
2. That there be established a Commission on Memorials to accept gifts to the Association; to acknowledge generosity in the name of the Association; and to preserve or use contributions according to the wishes of the donor.

Acknowledgement

No three members could make any significant contribution to the volume of thought, judgment, and effort which the new home represents. We have never in our experience in this or in any other organization, encountered the good will which has attended our work on this building. Officers, members, employees, or friends—none of those whom we have required to walk a mile with us have failed to walk the Scriptural second mile, and yet another mile for good fellowship. Seldom, surely, have so few been helped so much by so many.

KSMA Building Committee
N. Lewis Bosworth, M.D., Lexington
Hoyt D. Gardner, M.D., Louisville
George F. Brockman, M.D., Greenville
Chairman

Again this year, I thank the co-chairmen of this committee for their devotion and diligence. Unselfishly, they have worked far beyond any reasonable efforts the Association might expect of the most loyal members. I cannot commend to you too highly the services of N. Lewis Bosworth and Hoyt D. Gardner.

Supplementary Report of Building Committee

On August 16, 1961, the following gem appeared in a Louisville newspaper, as an account of a meeting of the Metropolitan Sewer District Board. The Board:

". . . agreed reluctantly to pay the Kentucky State Medical Association $1,500 for an easement across the KSMA property at Janet Avenue and Abigail Drive. The MSD thought the KSMA should have given the easement for the extension of the Goldsmith trunk sewer free, as the neighboring Jewish Community Center did. When the KSMA, which is building a headquarters on the site, refused, MSD filed a condemnation suit. The doctors' association offered to settle for $1,500 and MSD attorney Raymond Bossmeyer advised the board to pay it rather than incur the expense of pushing the suit."

The item apparently escaped the attention of KSMA newspaper readers as it only came to the notice of this Association when forwarded to the September meeting of the Building Committee. Doctor Bosworth, who is also chairman of the Council on Communications and Public Service, felt it essential that this record be corrected. The lapse of three weeks was thought to make it rather stale as material for the daily press. With the cooperation of Mr. E. Gaines Davis, Jr., the following statement is made as a supplementary report, and for publication in The Journal for the information of Association members:

"The Metropolitan Sewer District is an arm of government charged with providing sewer and drainage facilities in Jefferson County. The Jewish Community Center, which we are proud to have as a neighbor of our new headquarters, is a worthy institution, supported by the contributions of the generous people of Jefferson County, and properly exempt from local property taxes.

KSMA, as a non-profit body organized exclusively for educational and scientific purposes, could request exemption from the payment of local taxes. We have never felt that we should avoid payment for our share of the cost of police and fire protection which we receive, and the Association has appeared on the property rolls, as a taxpayer, for years.

A few months ago the Metropolitan Sewer District found need for a right-of-way across Association property, and offered to pay us $1,167. While negotiations were conducted by our counsel in the usual manner, we purchased an adjacent lot, adding 80 feet to the needed right-of-way. We offered to accept $1,500 for the right-of-way and a temporary easement for use of additional land during the construction. This was declined, and in the course, condemnation proceedings were instituted. The court-appointed appraisers valued the right-of-way at $1,000 (which was less than the MSD had offered before we bought the 80 feet of additional frontage), and recommended an additional $200 for the temporary easement.

On recommendation of the Building Committee, the Board of Trustees authorized our counsel to compromise and settle the entire easement for $1,500 if possible.

On August 16, an article in the local press reported that the Board of the Sewer District has "reluctantly" agreed to this payment, comparing the Association unfavorably with the Jewish Community Center, which had donated the right-of-way and easement requested of them. At least one MSD Board member has been reported as carrying this attitude into private social conversation, noisily berating this Association for accepting payment for the land.

The Building Committee and the Board of Trustees are disturbed at this churlish attitude on the part of the Board of the Sewer District. This Association receives no benefits from Jefferson County for which, as a taxpayer, we do not pay, and is therefore not comparable to the Jewish Community Center. We submit that neither legal nor moral principles require that our statewide membership abandon good objectives to make a disproportionate contribution to the solution of local sewage and drainage problems in Jefferson County."

Fallout Shelter

In view of the present news bulletins, the committee reports that the architect is providing a fallout shelter in the headquarters building.

Commission on Memorials

In the annual report, this committee recommended the establishment of a "Commission on Memorials." We would like to add a note of urgency to that recommendation. Since our annual report was mailed to the delegates, the committee has received checks from members who want to help in furnishing the headquarters building as memorials. The checks total $2,500.

Recommendations, Reference Committee No. 7

The Report of the Building Committee was reviewed with great interest and several members of the Committee made a "Cook's Tour" of the new building which is in a partial stage of completion. The Committee members as a whole were much impressed with the physical plant and feel that the Society owes a debt of gratitude to the Building Committee members for their excellent work. The Committee learned that at the present rate of expense the overall total cost of building and furnishings estimated to come to, that $200,000 will be paid off in approximately five years without any increase in Society dues.

The Committee recommends that the construction proceed as planned toward probable completion in January. The Committee also recommends that a Commission on Memorials be appointed, perhaps by the President, or elected by the Board of Trustees, to accept gifts to the Association and to preserve or use

contributions according to the wishes of the donor at the discretion of this Commission.

Mr. Speaker, I move the adoption and implementation of this section of the report. Motion was seconded and carried.

Report of the Woman's Auxiliary to KSMA

The Woman's Auxiliary to the Kentucky State Medical Association has completed its thirty-eighth year. As president, I am pleased to present the following report.

The 1961 program emphasized Legislation, Health Careers, and Health Education Projects jointly executed with other organizations. Specifically the state projects included:

1. A survey of the eleven-year-old nurse scholarship program; expanded health careers activity.
2. Legislation—an Auxiliary Key-Contact system.
3. Publication of a McDowell House Catalogue; the installation of a show case in the Doctor's Shop in Harrodsburg.
4. A reprint of the Constitution and Bylaws.
5. The issue and adoption of a policy sheet, and
6. An evaluation and partial change in policy respecting the Health Citation Award.

The membership total of 1299 deserves analysis and critical evaluation. There was an increase of only four over last year, but an increase of 16 in the number of counties represented, an increase of 10 in the number of members-at-large, and the organization of one new auxiliary in Boyle County. On the 1961 Necrology list there were 10. Three organized counties, namely the Hardin, Rockcastle, and Shelby-Oldham-Henry Auxiliaries, were lost. In two instances the loss was credited to the few eligible members within the respective counties, but the third was explained as primarily frictional, and beyond the control of the members.

All 26 auxiliaries actively promoted the state and national program, and engaged in numerous community health projects, independently, or in cooperation with local organizations. These projects included:

1. Recreational programs for senior citizens
2. Homemaker services
3. Health career clubs in high schools
4. Essay contests
5. Health drives
6. Local clinics
7. Chronic illness centers
8. Rehabilitation projects
9. Rural health programs—immunization, physical examinations of public school children, education for improved sanitation and preventive measures, participation in the Rural Health Conference in Morehead and planning the 1962 Conference at Kentucky Dam Village, and
10. Political action group

All county auxiliaries rendered volunteer services to hospitals, nursing homes, schools for retarded children, mental health projects, and numerous health drives. They contributed financially to AMEF, local and state benevolence scholarship funds and hospital equipment.

The benevolent contributions of six counties totaled $140.00. Eight counties contributed $2290.50 for scholarships. Two gave $730.00 for furnishing and equipping rooms in hospitals and nursing homes and in one specialized school. The total county contributions of $3160.50 plus the state scholarship loan of $800.00 and $150.00 benevolence for the college tuition of a deceased physician's daughter, equaled $4110.50, a significant fund for health and health education in Kentucky this year.

Thirteen scholarships and/or loans were given to nurses by counties, and two by the state. The survey report stimulated expanded health career activities. Some scholarship money was used for careers other than nursing.

Health Career activities included participation in Career Day programs, conducting hospital tours, participating in panel discussions and cooperating with councilors and P-TA. groups. Letters concerning health careers were sent to 209 school districts. The mimeographed materials distributed included: 1. Program aids for interested groups, 2. Scholarship-Loans-Training Grants available in Kentucky, and 3. A directory of schools in Louisville and Jefferson County offering professional training in the several health careers.

Effective legislation was primary in both county and state programs. Individual members actively engaged in political action groups, supported physician candidates in campaigns for school board elections, and addressed community organizations regarding health legislation. Articles comparing the provisions of the Kerr-Mills law with those proposed in the King-Anderson bill were published in some local papers and in our state Blue Grass News. Three county Auxiliaries sponsored radio programs. The state president participated in one of these, discussing over the Owensboro station, "Medical Care for the Aged."

State-wise, an Auxiliary Key-Contact Legislative System was organized by Mrs. F. H. Hodges, State Legislative chairman. Over this network, Auxiliary members throughout the state were alerted on two occasions when action was requested by the KSMA office. Letters and telegrams were sent to Congress.

Fourteen members attended, with KSMA delegates, the 4th Annual Dinner for Kentucky Congressmen and Senators in Washington, February 23, 1961. On this occasion the Auxiliary delegation discussed with Kentucky representatives, the current legislation measures pertaining to medicine and health.

All county auxiliaries cooperated to promote the success of the "Operation Coffee Cup" campaign. We hope our efforts to send 1000 letters a week to Congressmen helped to accomplish the desired results.

During my year as president-elect, Mrs. Walker Owens, Chairman of our McDowell House Shrine, proposed the publication of a Catalogue on the furnishings within the shrine, which would include a brief historical sketch. She recommended placing the catalogue on display in McDowell House for sale to visitors. This year the state auxiliary contributed $150.00 for the publication of this catalogue, prepared and edited by Mrs. James Rich, and underwrote the project. The catalogue is now on sale at McDowell House. It should be of interest to all visitors, serve a worthy purpose, and eventually pay for the publication.

The search for a showcase for the Doctor's Shop in Harrodsburg, ended in February when the Mary Chiles Hospital Auxiliary in Mt. Sterling gave one to the state auxiliary. It is now installed and the antique physician's tools and implements are properly displayed.

The many revisions in our Constitution and Bylaws, effected during the past nine years, necessitated reprinting this document. The 1961 publication was supplemented by a mimeographed policy sheet comparable to that of a handbook, which is designed for orientation purposes, to facilitate administrative functions, stimulate continuity and better communication, and provide for simple operational changes without necessitating frequent Constitutional and Bylaws revisions.

The Auxiliary Health Citation Award, unique in some respects, was continued with one change. Hitherto, no financial remuneration accompanied the citation. Henceforth, if the project developed by the winner needs and merits financial assistance, a token financial gift may accompany the citation, if it is recommended by the State board.

In addition to promoting the above specific state projects, the Auxiliary conscientiously pursued the National Auxiliary program and records the following actions:

AMEF—The donations received from projects, individuals, and tokens of appreciation were $1181.00.

Bulletin—The state does not inclule subscription to the Bulletin in either the national or state dues, although somc counties do. The majority of board members, both on the state and county levels, did subscribe to this "text book."

Civil Defense—Activity in this field by County Auxiliaries included establishing a speakers' bureau, attending first-aid classes, and distributing materials on building shelters. Five counties actively promoted the SWAT program, developed program on poison control, senior citizen safety, "Gems" and farm safety in cooperation with local Fire Departments, P-TA groups and the Y.M.C.A. Two counties promoted traffic safety through high school training courses in driving.

Mental Health—Much of the work in mental health was in cooperation with schools for retarded children. However, individual members served on Mental Health boards in two counties, and one served as an active member of the State Mental Health Association board. County Auxiliaries consistently worked with the Kentucky Federation of Women's Clubs in Mental Health actions.

In many instances, regularly scheduled visits to patients in the three state mental hospitals were a part of the County activities. Gifts were provided for patients on special holidays. In one instancc $55.00 was donated to Central State Hospital to be used to cover the court costs for the restoration of legal rights to discharged patients.

Publications—The official publication of the Auxiliary is that of the State Medical Association. the *Journal,* but the Auxiliary published quarterly, the state Bulletin, the *Blue Grass News.* This was sent to all members. Three times during the year, a News Letter was sent to all board members from the state president.

At the present, the official records of the Auxiliary are held by the president. We look forward to the day when records may be stored in an Auxiliary room in the Headquarters Building of KSMA.

Other activities included cooperation with state and local Heart Associations, T.B. Associations, Cancer Societies, and the KSMA Senior Day Program.

The annual Cancer Speech Contest was not sponsored by the Auxiliary this year. Mr. Charles Tucker, Executive Secretary of the Kentucky Cancer Society, met with the state auxiliary board in November and agreed to reorganize the program on a district basis. The board voted to sponsor the Speech Contest next year under the new plan.

On March 20, the Auxiliary entertained the wives of Senior medical students at a tea and presented to the guests an orientation program designed to interest the wives of young physicians in Auxiliary membership and program activities.

Eight Auxiliary members attended the KSMA State Officers' conference in Lexington, April 6. Four were official delegates to the National Convention of the Woman's Auxiliary to the American Medical Association in New York City, June 26-28.

President's Report

As president-elect and president, I attended the Annual Convention of the Woman's Auxiliary to the American Medical Association in Miami, 1960 and New York City in 1961, two fall conferences for state presidents and presidents-elect in Chicago, the Kentucky Rural Health Conference in Morehead, 1960, a meeting of the KSMA Legislation Committee in Louisville, the KSMA Officers' Conference in Lexington, a board meeting of the Kentucky Rural Health Council in Louisville, and as a delegate sent by KSMA to the 4th Annual Visit with Kentucky Congressmen and Senators in Washington. I presided at four State Auxiliary board meetings, the Senior Day Auxiliary Tea, and the State Auxiliary Convention in Louisville, September 19-20-21, 1961.

Other visits included attending district meetings in Ashland and Henderson, annual meetings of county auxiliaries in Frankfort, Lexington and Owensboro where I addressed the Auxiliaries and installed the new officers. In January, I addressed the Jefferson County Auxiliary in Louisville. Three trips were made to Danville, two for purposes of organizing the new auxiliary in Boyle County and the other to attend the opening of the McDowell House Shrine for the summer season. Three state visits were made to attend special committee meetings. In May I attended a meeting in Frankfort at the Kentucky Health Department on the occasion of the unveiling of the McDowell painting.

Visits to other state auxiliary conventions included Ohio, Illinois, Indiana, and West Virginia.

At the New York City National Convention, June 1961, I was a participant in the program, presenting the "In Memoriam" service and the Kentucky Presidential Report. While at the convention I represented Kentucky at an Associated Press interview along with the national president, Mrs. Harlan English, and the Indiana president, Mrs. Butram Kitner. This release was published in newspapers throughout the nation. Also, at the convention, I was nominated by the National Auxiliary to serve on the AMPAC committee, established by the AMA House of Delegates. My appointment by the AMA Board of Trustees was released to the press on July 19, 1961.

During the year I wrote an article for each issue of Blue Grass News, three news letters to board members, two reports for the National Auxiliary Bulletin, an article for the president's page of the KSMA Journal, February issue, and a report of the Kentucky Auxiliary activities for the National archives. My inaugural address, given at the 1960 state Convention, was published as a special featurc in the May 1961 National Auxiliary Bulletin.

In March 1961 I accepted, on the invitation of the National President, an appointment to serve on the National Publications Committee for 1961-62, and attended a meeting of this committee in Chicago, July 10-12, 1961.

The depth, breadth and significance of the work summarized in this report is credited to the entire auxiliary membership and the leaders with whom I have been privileged to serve. It is my pleasure to thank, for the Auxiliary, the Parent Organization for the opportunities and challenges presented, the Advisory Committee for prompt and wise direction, and the KSMA Executive Staff whose cooperation and enthusiasm was pleasant and profitable.

Nancy E. Roles
President
Woman's Auxiliary to the Kentucky
State Medical Association

Recommendations, Reference Committee No. 7

The Committee learned with great interest of the varied and extremely worthwhile activities of the Woman's Auxiliary Organization. A summary of these projects is contained in the main body of the report. The Committee recommends that the Society commend the Woman's Auxiliary for their excellent work during the past year.

Mr. Speaker, I move the adoption and implementation of this section of the report. Motion seconded and carried.

Representative on the Advisory Committee on Maternal and Child Health

There has been no meeting of the Advisory Committee on Maternal and Child Health to the State Health Department insofar as I know.

I have not been contacted this year concerning any meeting or business matters for this committee.

William H. Parker, M.D., Owensboro
Representative

Advisory Committee on Maternal and Child Health to the State Health Department

Recommendations, Reference Committee No. 7

There has been no meeting of the Advisory Committee on Maternal and Child Health this year.

Mr. Speaker, I move the acceptance of this section of the report. The motion was seconded and carried.

Mr. Speaker, I move the adoption of this report as a whole. Motion seconded and carried.

Reference Committee No. 7

W. E. Becknell, M.D., Manchester
J. M. Hunt, Jr., M.D., Wickliffe
James B. Douglas, M.D., Louisville
Frank Duncan, M.D., Monticello
Robert S. Tillett, M.D., Louisville, Chairman

Unfinished Business

It was stated that there was no unfinished business at this time. The speaker expressed appreciation for the spirit of cooperation and good will of the delegates.

Election of Officers

The report of the nominating committee was presented by William E. Oldham, M.D., Louisville. A motion was made, seconded and carried that the nominations to fill the vacant offices for the 1961-62 year be closed and the following nominees were presented:

President Elect	David M. Cox, M.D., Louisville
Vice-Presidents	
Central	Henry B. Asman, M.D., Louisville
Eastern	R. E. Pennington, M.D., London
Western	Walter Johnson, M.D., Paducah
Delegate to the AMA	George P. Archer, M.D., Prestonburg
Alternate to the AMA	Thomas P. Giannini, M.D., Louisville
Delegate to the AMA	J. Vernon Pace, M.D., Paducah
Alternate to the AMA	John Quertermous, M.D., Murray

After each nomination was presented, the speaker called for nominations from the floor but none were made. It was moved, seconded and carried that the secretary be instructed to cast one ballot and that the list be elected, as submitted, by one vote.

It was explained that a vacancy had been created by the election of Doctor Acher to AMA delegate from alternate delegate. The name of Carl Cooper, M.D., Bedford, was nominated. Motion was made that nominations cease, was seconded and carried. It was moved seconded and carried that the secretary be instructed to cast one vote for the election of Doctor Cooper as alternate delegate to Robert C. Long, M.D., AMA delegate.

Election of Trustees

Second District	Howell J. Davis, M.D., Owensboro
Seventh District	Wyatt Norvell, M.D., New Castle
Ninth District	Mitchell Denham, M.D., Maysville
Tenth District	Douglas E. Scott, M.D., Lexington
Thirteenth District	Clyde C. Sparks, M.D., Ashland

The same procedure followed in electing the general officers was followed in the election of the trustees.

The following men were asked to escort the new president-elect to the rostrum: Irvin Abell, M.D., Hugh L. Houston, M.D. and Robert W. Robertson, M.D. Doctor Cox made brief remarks following a standing ovation.

Nominations for Board of Directors, Kentucky Physicians Mutual, Inc.

The following list of nominees for the Board of Directors, Kentucky Physicians Mutual, Inc. was submitted at this time and received for information only:

Braham B. Baughman, M.D., Frankfort
J. Randolph Buskirk, M.D., Louisville
A. L. Cooper, M.D., Somerset
Mr. R. A. Dean, Sr., Louisville
J. B. Lukins, M.D., Louisville
W. K. Massie, Jr., M.D., Lexington
W. Vinson Pierce, M.D., Covington
John C. Quertermous, M.D., Murray
Charles E. Rankin, M.D., Lexington
R. W. Robertson, M.D., Paducah
Joseph H. Saunders, M.D., Lexington
Charles B. Stacy, M.D., Pineville
Russell E. Teague, M.D., Frankfort
Walker Turner, M.D., Paducah
Leslie H. Winans, M.D., Ashland
Robert McClendon, M.D., Louisville
George J. Hermann, M.D., Fort Thomas

Election of 1962 Nominating Committee

The nominating committee to serve at the 1962 Annual Meeting was duly elected as follows:

W. H. Bryant, M.D., Glasgow
A. D. Butterworth, M.D., Murray
M. C. Darnell, M. D., Lexington
Russell L. Hall, M.D., Prestonsburg
William E. Oldham, M.D., Louisville

At this time, Gaithel L. Simpson, M.D., Greenville, was installed into office by the administration of the oath of office by the chairman of the Board of Trustees, J. M. Stevenson, M.D., Brooksville.

The new president's first official act was that of presenting the past-president's key to the retiring president, Richard G. Elliott, M.D., Lexington. Doctor Elliott expressed his appreciation for the cooperation he had received during his administration.

Doctor Overstreet thanked the House for its attentiveness during both sessions. There being no further business, a motion was made, seconded and carried that the 1961 meeting of the House of Delegates adjourn at 11:00 p.m.

Doctor and Mrs. R. E. Pennington were grand prize winners in the London city beautification contest which closed October 1. Doctor Pennington is KSMA's Eastern district vice president.

William E. Adams, M.D., Paducah, has announced the closing of his offices for approximately one year. Doctor Adams has been called to active military duty.

Dale Q. Furnell, M.D., a 1946 graduate of the University of Minnesota School of Medicine, has opened an office in Paducah where he will limit his practice to orthopaedic surgery. A native of St. Paul Minn., Doctor Furnell took his internship at Ancker Hospital, St. Paul, and residency training in general surgery at two other St. Paul hospitals: Abbot and Northern Pacific. He took residency training in orthopaedic surgery at Georgetown University, D.C. General Hospital, and Northwestern University. He had a practice in St. Paul from 1949 to 1954; was a major with the Medical Corps from 1954-56, and was on the clinical research staff of G. D. Searle and Company until 1960.

ORGANIZATION SECTION

KSMA Interim Meeting To Have Five Top Speakers

Five highly rated and nationally recognized speakers will participate in the Interim Meeting program at Owensboro, Thursday, February 22, G. L. Simpson, M.D., Greenville, chairman of the interim program committee, has announced.

Among one of the top speakers will be Carl R. Ackerman, M.D., who is director and chairman of the Board of the United Medical Service in New York, the largest Shield Plan in the Country. Doctor Ackerman will discuss, "How Private Practice Can Survive."



Carl R. Ackerman, M.D.

He had a medical practice in Bronx, N. Y. from 1933-60, is a member and past president of the Bronx County Medical Society. He has been vice chairman of the Board of Directors, National Association of Blue Shield Plans, since April 1961.

Sharing the morning program with Doctor Ackerman will be Wesley W. Hall, M.D., AMA trustee from Reno, Nevada, along with Austin Smith, M.D., of Washington, D. C., former editor of The Journal of the AMA and now president of the Pharmaceutical Manufacturers Association.

These are three excellent speakers, Doctor Simpson said; and following their presentations on the morning of February 22, a question and answer session will give the audience an opportunity to question each of these men.

The Interim Meeting, formerly known as the County Society Officers Conference, will be held at Gabe's Restaurant in Owensboro. Under recent policy of the Board of Trustees, the Interim Meeting is held in even-numbered years at Owensboro and in the odd-numbered years at Lexington.

Full program for the 1962 meeting will be carried in the January issue of The Journal of KSMA.

This Is Important To You

Each of the 15 KSMA Trustee Districts have been asked to schedule special meetings in January or February. KSMA President Gaithel L. Simpson, M.D., Greenville, has urged each member to be on the lookout for his personal invitation to the meeting of his district and to make every effort to attend that meeting. Additional information will appear in the Secretary's Letter and News Capsules.



Opening the program of the Rural Health Conference were seated left to right: Hugh McElrath, D. D. S., Murray; Malcolm H. Black; and Gaithel L. Simpson, M.D., Greenville. Standing left to right are: Russell E. Teague, M.D., Frankfort; A. B. Dickey, M.D., Madisonville; and Thomas M. Layton.

215 Attend Annual Rural Health Conference

A record 215 people attended the ninth annual Kentucky Rural Health Conference at Gilbertsville on November 2. Thirty-one counties were represented and more than 21 organizations.

J. C. Salato, M.D., Columbia, was elected chairman of the Kentucky Rural Health Council which sponsored the conference. He succeeds Nathan Canter, M.D., Owensboro. The Council was founded by the KSMA in 1951.

Elected vice chairman was Charles Dion, Lexington, of the Extension Service. Mrs. Paralee Roberts, Louisville, with the Kentucky Farm Bureau, was chosen secretary-treasurer.

The conference was highlighted by discussions of tuberculosis and a panel on tooth decay and how to prevent it. Guest speakers included: A. B. Dickey, M.D., Madisonville; Russell E. Teague, M.D., Frankfort, State Commissioner of Health; Thomas M. Layton, Frankfort, executive director of the State TB Hospital Commission; Thomas P. Summers, Louisville, executive director of the Kentucky TB Association; Hugh Houston, M.D., Murray; Oren A. Beatty, M.D., Louisville; D. D. Turner, M.D., Marion; and Abram Allen, D.V.M.

Participants on the panel on tooth decay were E. B. Gernert, D.M.D., Frankfort; A. H. Titsworth, D.M.D., Murray; Hal Boyer, D.D.S., Louisville; and D. C. Carter, D.M.D., Bowling Green.

Speaker at a luncheon session was P. F. Ayer, Berea, executive secretary of the Council of the Southern Mountains, Inc., who discussed, "Better Health to What End."

The tenth annual conference is scheduled to be held November 1, 1962, at Cumberland Falls State Park.



Participants in the afternoon session of the Rural Health Conference were; left to right. A. H. Titsworth, D.M.D., Murray; E. B. Gernert, D.M.D., Frankfort; Mrs. Carl Evans, La Center, who presided; C. D. Carter, D.M.D., Bowling Green; and Hal Boyer, D.D.S., Louisville.



Shown above are members of the panel on "How to Use Our Resources," presented at the morning session of the Conference. They are, left to right: D. D. Turner, M.D., Marion; Thomas P. Summers, Louisville; Viola Hanson; Hugh Houston, M.D., Murray; Oren A. Beatty, M.D., Louisville; and Abram Allen, D.V.M., Paducah.

Dr. Simpson Urges County Elections, Reports

Because of the importance of the year 1962 to medicine and to the public in the field of health care and related matters, according to G. L. Simpson, M.D., Greenville, KSMA president, medicine should be at its full organizational strength from the very start of the year.

With this in mind, Doctor Simpson urges each county medical society to hold its election of officers and submit the names of these officers to the headquarters office in Louisville as soon as possible. Forms on which to make these reports were mailed late last month to the county society secretaries of record for the year 1961.

Doctor Simpson pointed out that it was very important that all county society officers and committee personnel be invited to the Interim Meeting at Owensboro on February 22. An early election by the county societies will enable the new officers to receive special invitations and make their plans to attend this important meeting.

New Headquarters Building Nearing Completion

Plans are underway for moving into the new headquarters office building at 3532 Janet Avenue, Louisville, near the first of the year, according to George F. Brockman, M.D., Greenville, chairman of the KSMA Building Committee.

Progress on the new building, which is located in the northwest quadrant of the Watterson Expressway and Taylorsville Road, is satisfactory. Certain difficulties, however, in obtaining basic equipment may cause delays to some extent, Doctor Brockman said.

The committee has been holding frequent meetings, spending much time in inspecting equipment, seeing suppliers and endeavoring to come up with the best possible end result for the Association, Doctor Brockman said.

The building committee has recommended that dedication of the new structure be held on May 20, and the Board of Trustees has approved the recommendation. Other members of the building committee are N. Lewis Bosworth, M.D., Lexington, and Hoyt D. Gardner, M.D., Louisville.

Kentuckians Prominent At 55th Southern Medical Meeting

A. Clayton McCarty, M.D., Louisville, was installed as president at the 55th annual meeting of the Southern Medical Association in Dallas, Texas, November 6-9, and Fount Richardson, M.D., Fayetteville, Ark., was made president-elect. J. Duffy Hancock, M.D., Louisville, was named to the executive committee of the Council for a one-year term.

The Woman's Auxiliary of the Southern Medical Association chose Mrs. Robert F. Monroe, Louisville, as third vice president. Mrs. Roy A. Douglas, Huntingdon, Tenn., is president, and Mrs. Elias Margo, Oklahoma City, Okla., is president-elect.

Members and guests from 39 states and five foreign countries attended the meeting, with a total registration of some 4,500.

Presented with the Seale Harris Award was Henry H. Turner, M.D., Oklahoma City, Okla., a classmate of Woodford B. Troutman, M.D., KSMA secretary, and J. Duffy Hancock, M. D., both of Louisville, at the University of Louisville School of Medicine in 1921.

The Distinguished Service Award of the Southern Medical Association went to George E. Burch, M.D., New Orleans, La., and the Research Medal for meritorious and original research work in contributing to medical science to May Owen, M.D., Fort Worth Texas, a past president of the Texas Medical Society. Doctor Owen is also a 1921 graduate of the U. of L. School of Medicine with Doctors Troutman and Hancock.

Outstanding features of the meeting were four special symposia, a public telecast, and a series of scientific color television presentations. Another Kentuckian, Robert Lich, Jr., M.D., Louisville, was one of the speakers at the meeting.

Sixth District Elects Dr. Dickinson

John Dickinson, M.D., Glasgow, has been elected president of the KSMA's Sixth Trustee District. Other officers elected at a recent meeting were: Lycurgus E. Johnson, M.D., Russellville, vice-president; and

Paul J. Parks, M.D., Bowling Green, secretary.

Elections were held at a meeting of the Sixth Trustee District November 16 at the Russellville Country Club.

Speakers at the meeting were David M. Cox, M.D., Louisville, KSMA president-elect, who discussed, "The Long Term Treatment of the Chronically Ill," and Ludwig H. Segerberg, M.D., Louisville, who talked on, "Hypothermia in the Treatment of Head Injuries."

U. of L. Announces Changes In Medical School Faculty

New appointments and other changes in the faculty have been announced by the University of Louisville School of Medicine.

Receiving appointments were: Mary Matilda Morrow, M.D., and William Bailey Stodghill, M.D., instructors in medicine; Peter Rieser, M.D., assistant professor of physiology; David Ernest Irigoyen-Villarreal, M.D., instructor in psychiatry; Martyn Alan Goldman, M.D., and William Charles Mitchell, M.D., instructors in orthopaedics in the department of surgery; John J. Phair, M.D., lecturer in community health; George Irvin Uhde, M.D., named acting chief of the section on otorhinolaryngology of the department of surgery; and William Henry Marshall, M.D., instructor in surgery.

An additional appointment as associate in the department of radiology was given Adolph T. Krebs, M.D. William A. Brodsky, M.D.; Malcolm Stanley, M.D., and Gaspar Carrasquer, M.D., were given additional appointments as associates in physiology. Daniel Stowens, M.D., will also serve as an associate in pediatrics.

Promotions to assistant professor of urology were announced for the following: Lytle Atherton, M.D.; Chapman S. Moorman, M.D.; L. Douglas Atherton, M.D.; Avrom Issacs, M.D.; George A. Sehlinger, M.D., and Joseph A. Maurer, M.D. Other promotions were: Robert A. Tolman, M.D., to assistant professor of physiology; Ellis A. Fuller, M.D., to assistant professor of medicine; and Sheppard M. Walker, M.D., to professor of physiology.

Resignations were accepted from Waldo D. DeVore, M.D., assistant professor of radiology; Edwin W. Nolan, M.D., instructor of ophthalmology in the department of surgery; and Homero F. Nino, M.D., instructor in radiology.

Blood Bank Association To Be Organized In Kentucky

The Kentucky Society of Pathologists is sponsoring an organization meeting for a Kentucky Association of Blood Banks, according to H. Davis Chipps, M.D., Lexington. Doctor Chipps is president of the Kentucky Society of Pathologists and the Kentucky representative to the American Association of Blood Banks.

Arrangements have been made to hold the meeting at the University of Kentucky School of Medicine, Room MN 263, at 2 p.m., December 16.

It is anticipated that the members of the Kentucky Society of Pathologists, the Kentucky members of the American Association of Blood Banks, and other professional and administrative blood bank personnel from hospitals or other medical institutions will be interested in attending this organization meeting. Anyone who is interested is invited to attend.

NOTE

To County Society Secretaries and Members

Annual AMA dues will be increased $10 on January 1, 1962, and an additional $10 on January 1, 1963, following action by the AMA House of Delegates in New York, June 26. When this increase becomes effective, the annual dues for active members will be $35 a year in 1962 and $45 in 1963. This is the first AMA dues increase in 12 years.

New Program Begun At U.K. Medical School

The Department of Biochemistry of the University of Kentucky College of Medicine has received the approval of the University Faculty for establishment of its proposed program for graduate study. The facilities of the department are still being developed, but are adequate for investigation in most fields of biochemistry, according to George W. Schwert, Ph. D., chairman of the department.

Other members of the department are: Richard S. Schweet, Ph. D., professor; Robert L. Lester, Ph. D., associate professor; Alfred D. Winer, Ph. D., assistant professor; Alfred E. L. Hu, Ph. D., assistant professor, and John C. Dittmer, Ph. D., assistant professor.

Recent appointments to the faculty of the College of Medicine include the following: Thomas M. Cassidy, M.D., appointed clinical instructor of psychiatry; John A. Shively, M.D., appointed associate professor of pathology; and Joseph C. Tatum, M.D., appointed clinical assistant professor of psychiatry.

Dr. Brown, Visiting Professor, Lectures At U. of K.

The U. of K. department of pathology is being joined by Harold W. Brown, M.D., a visiting professor of pathology. Doctor Brown, who is professor of parisitology at Columbia University's College of Physicians and Surgeons, is scheduled to assist with the lectures on "Parasitic Disease of Man." The course is a portion of the second year curriculum, offered by the department of pathology.

Doctor Brown is also a past director of the School of Public Health and Administrative Medicine at Columbia and is President of the Board of Medical Examiners of the University of the State of New York.

He holds an A.B. degree from Kalamazoo College; an M. S. from Kansas State College; an Sc. D. from Johns Hopkins; an M.D. from Vanderbilt; and a Dr. P. H. from Harvard University School of

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Public Health. He has been associated with Columbia's College of Physicians and Surgeons since 1943.

Recent appointments to the University of Kentucky College of Medicine have been announced by the College. They are: Barbara Bates, M.D., appointed assistant professor of medicine; John S. Chambers, M.D., appointed emeritus professor of medicine; Loren J. Chapman, Ph. D., appointed associate professor of psychiatry (part-time); William H. McBeath, M.D., appointed teaching and research assistant in the department of community medicine (part-time); Frank Spencer, M.D., appointed professor of surgery; and Basil Sherlock, Ph. D., appointed instructor of behavioral science.

Mid-South Assembly Scheduled

Nineteen guest speakers are scheduled to participate in the 73rd annual meeting of the Mid-South Postgraduate Medical Assembly. The meeting will be held February 13-16, 1962, in Memphis, Tenn.

Dr. Bernhard, Sholis Elected

The American Cancer Society, during a meeting October 25 in New York, elected C. Melvin Bernhard, M.D., Louisville as a director of the Society. Doctor Bernhard is a former president of the Kentucky division.

Victor A. Sholis, vice president and director of WHAS and WHAS-TV, Louisville, was also chosen as a director. He is a former regional director.

Student AMA

University of Kentucky

The University of Kentucky Chapter of the Student American Medical Association was the host school for the Fall Region #4 meeting of the Student AMA the last weekend in October. There were 26 delegates from Student AMA Chapters at Indiana, Michigan, Wayne State, Vanderbilt, Ohio State, Louisville, and Cincinnati at the meetings held at the University of Kentucky Medical Center from the 27th through the 29th of October.

After their arrival on Friday evening, the delegates were shown around the dental and medical science wings of the Medical Center, then were taken to homes of faculty members where they stayed while in Lexington.

At eight a.m., Saturday, the 28th, the delegates were the guests of the Kentucky State Medical Association at a buffet breakfast served by the University of Kentucky Medical Students Wives Club. Saturday morning meeting, under the direction of Rudy Kachmann, regional vice president, Indiana, included a report on chapter business from each school present and a discussion led by Hoyt D. Gardner, M.D., of Louisville, on current legislation affecting medicine.

After a noon luncheon in the Student Union Football Room, sponsored by the Fayette County Medical



Posing after the luncheon at the SAMA Region Four convention at the University of Kentucky Medical Center were: seated left to right, Hoyt Gardner, M.D., Louisville, KSMA advisor to the University of Louisville Chapter; Ballard D. Wright, University of Kentucky, Chairman of the Hospitality Committee; Joe Clark Christian, University of Kentucky, president of the host chapter; and M. C. Darnell, M.D., Lexington, Fayette County Medical Society Advisor to the Kentucky chapter. Standing left to right are: Michael F. Wilson, M.D., University of Kentucky Chapter advisor; John J. Hutton, Kentucky delegate to the SAMA convention; Billy Mac Young, University of Kentucky, chairman of the Arrangements committee; and Richardson K. Noback, M.D., University of Kentucky chapter advisor. (Unfortunately it was not possible to get Richard H. Segnitz, M.D., Lexington, KSMA advisor to the University of Kentucky chapter, or William R. Willard, M.D., Lexington, dean of the U. of K. Medical School, in this photograph.)

Association, the delegates toured several Bluegrass horse farms, and then were shown through the nearly-completed 500-bed University of Kentucky Hospital.

Kurt Deuschle, M.D., head of the department of community medicine of the University of Kentucky Medical School spoke to the delegates Saturday evening after a dinner at the Campbell House. Doctor Deuschle spoke on "New Ideas" and how the department of community medicine arose as a new idea to better serve the health needs of the people of Kentucky.

Sunday morning the delegates were breakfast guests of Blue Cross and Blue Shield. After breakfast, Avil McKinney, director of Physicians Service, and Jim Franklin of Blue Cross and Blue Shield, discussed the future of their organization in medical care. After a business meeting, Rudy Kachmann, regional vice president, announced that the spring meeting would be held at Ohio State and declared the meeting adjourned.

The University of Kentucky Student American Medical Association is very grateful for the help of the State and Local Societies, the faculty, Blue Cross and Blue Shield and our wives for helping to make these meetings possible. We feel that we were able to acquaint students from other schools with our new school and also gain valuable experience talking to students from other schools about problems of mutual interest.

Joe C. Christian, President
University of Kentucky Chapter
Student American Medical Association

University of Louisville

The new school year at U. of L. has seen significant changes take place in the curriculum of the medical school, in particular relationship to the junior and senior years. The change has been marked in the Department of Surgery, and is one which appears to be in keeping with advancing changes of medical education throughout the nation.

While a junior, the student is now being oriented in all phases of the surgical sub-specialities, either by lecture, clinic, or in some cases, both. The added responsibilities of emergency room duty, surgical patient care, assisting in the operating room, and ward duty have been largely relegated to the senior year.

Thus more mature and better grounded individuals are placed in a position of greater responsibility as far as patient care is concerned and at the same time, such students gain a fuller measure of worth from their new duties, due to a more adequate background during the junior year. The end result, of course, is a much more coordinated and improved two year surgical rotation than was formerly offered the student.

Thus the Department of Surgery at U of L has visualized the need for continuing change in methods of medical education, and it is not hard to foresee that U of L graduates will continue to make their presence known in the field of medicine due to just such efforts to better educate them. In the future, no doubt, more changes in all departments will be needed and will be accomplished, as has been the case since our school was first begun.

These changes, as are the present ones being undertaken, will not be without difficulty, for as someone has said, "all change, even for the better, is difficult." But the changes are absolutely necessary if our school is to continue to grow and keep pace with others in the nation.

We cannot continue this growth unless we realize that the Medical School is an institution dedicated to educating the future physicians of our state, and in many cases, the nation. To this end, it behooves all interested persons, students and faculty alike, to continually remind our city government and the people of Louisville how necessary it is for our school to continue its growth, its physical expansion, and its service to the community.

Just as various departments in the Medical School are changing to meet the changing needs in education so the whole school must grow through changes. The past history of our school is indeed significant, but its future history will depend largely on what is done to improve it today.

The student body of U of L's historic Medical School would indeed hope that the citizens of Louisville will join forces with their university so that the future for medical education in our area will remain bright.

Olson Huff, President
U. of L. Chapter SAMA

Editor's Note: With the activiation of the Student AMA Chapter at the U. of K. Medical Center, The Journal has invited this chapter to submit a monthly letter. This same invitation, of course, has been extended the U. of L. Chapter.

Leslie W. Langley, Jr., M.D., previously associated with **Robert N. McLeod, Jr., M.D.,** Somerset, in the practice of pediatrics, is opening a new office in Elizabethtown. The Elizabethtown practice will be limited to pediatrics, also. Doctor Langley received his medical degree from the University of Louisville in 1953 and interned at St. Joseph Infirmary, Louisville. He took residency training at Louisville General Hospital and the Children's Hospital, Louisville.

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Southern Medical Meeting Draws 46 Kentucky Drs.

According to reports from the Southern Medical Association, KSMA members registered at Southern Medical's annual meeting November 6-9 in Dallas, Texas, were:

Doctor and Mrs. C. M. Brassfield, Elizabethtown
Paul A. Bryan, M.D., Ashland
W. C. Buschemeyer, M.D., Louisville
Doctor and Mrs. Eugene A. Castle, Madisonville
Doctor and Mrs. Robert H. Cofield, Covington
Doctor and Mrs. Allen L. Cornish, Lexington
Owen L. Davis, M.D., Scottsville
Ralph M. Denham, M.D., Louisville
Edgar R. Franklin, M.D., Middlesboro
J. Thomas Giannini, M.D., Louisville
Doctor and Mrs. John D. Gordinier, Louisville
C. Y. Graves, M.D., Bowling Green
Doctor and Mrs. George Gumbert, Jr., Lexington
J. Duffy Hancock, M.D., Louisville
Clifford N. Heisel, M.D., Covington
Doctor and Mrs. Elmo K. Hughes, Pleasure Ridge Park
Doctor and Mrs. David L. Jones, Fulton
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R. Burke Suitt, M.D., Harlan
K. W. Taber, M.D., Drift
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Stanley Wassermen, M.D., McDowell
John C. Weeter, M.D., Louisville
Harry U. Whayne, M.D., Murray
Carroll L. Witten, M.D., Louisville
Doctor and Mrs. Raleigh Witten, Louisville

Thoracic Society Meets

The Kentucky Thoracic Society held a meeting October 27-28 at Lexington. Physician-speakers from Ashland, Harlan, Lexington, and Louisville were on the program. Subjects included heart-lung studies before lung surgery, disability due to thickening of lung tissues, and resistance of lung-disease germs to drugs.

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†*Appointed by the KSMA Board of Trustees, October 19, 1961.*

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Medical Assistants Hold Workshop

Sixty people attended a workshop held by the Jefferson County Medical Assistants Association on November 5 in Louisville. Highlights of the day-long program included a talk on "Medical Care for the Aged," by Gaithel L. Simpson, M.D., Greenville, KSMA president.

"Testimony on H. R. 4222 For House Ways and Means Committee Hearings," was discussed by Mrs. Bettye J. Fisher, immediate past president of the American Association of Medical Assistants. Robert C. Long, M.D., Louisville, KSMA's delegate to the AMA who testified before the House Ways and Means Committee on H. R. 4222, also talked on "Federal Aid for the Aged."

Members of the Association's Medical Advisory Committee discussed "Current Trends in Medicine." Speakers were: Walter Hume, Jr., M.D.; David M. Cox, M.D.; Jack L. Chumley, M.D.; David W. Kinnaird, M.D.; William E. Oldham, M.D.; and Robert L. Woodard, Jr., M.D.

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Postgraduate Office Begins New Calendar Listing Service

In a continuing effort to improve and increase its service to the physicians of Kentucky, the KSMA Postgraduate Medical Education office has undertaken a new project. This project is the preparation and maintenance of a calendar of local medical meetings.

It will also include meetings to be held in other areas of the country which will be of significance to local physicians. How successful this project will be depends on how efficiently and completely information can be gathered.

Therefore, the assistance of organized medical groups in the state is respectfully urged. As these groups schedule meetings, it is hoped that they will inform this office which in turn will incorporate the information in its calendar and also include it in its regular page in The Journal of the KSMA. The publication of this calendar begins in this issue.

The purpose of this new activity is two-fold. First, it will keep Kentucky's doctors up-to-date on what is going on, not only in their own state, but also in surrounding states. Second, it will do much to prevent conflicts in meeting dates and the attendant difficulties involved, such as a possible loss or decrease in attendance. You are urged to call the KSMA Postgraduate office before you schedule the next meeting of your organization.

Kentucky Activities

Dec. 14	**Fourth Annual Postgraduate Medical Seminar, Norton Memorial Infirmary, Louisville.**
Dec. 14	*Meeting of the KSMA Council on Allied Professions and Related Groups, Lexington.*
Dec. 21	*Meeting of the KSMA Council on Medical Education and Hospitals, Louisville.*
Jan. 18	**KAGP Northern Kentucky Seminar, Cincinnati.**
Jan. 24-25	**Postgraduate Course, ENDOCRINOLOGICAL DISEASE, University of Kentucky Medical Center, Lexington.**
Feb. 22	*KSMA Interim Meeting, Gabe's Restaurant, Owensboro.*
Mar. 5-7	Southeastern Surgical Congress, Louisville.
Mar. 16-17	Kentucky Chapter, American College of Surgeons Sectional, Lexington.
Mar. 20-22	Kentucky Hospital Association, Louisville.
Mar. 22	Kentucky Industrial Medical Association, Louisville.
Mar. 28-29	Jefferson County Chapter, American Heart Association, Louisville.

Surrounding States

Jan. 18	Postgraduate Course, Orthopaedic Treatment for the Office Patient, Vanderbilt University, Nashville, Tennessee.
Jan. 28-Feb. 1	Academy of Orthopaedic Surgeons, Chicago, Illinois.
Feb. 7-10	American College of Radiology, Roosevelt Hotel, New York.
Feb. 8	Postgraduate Course, Selected Problems in Infectious Disease, Vanderbilt University, Nashville, Tennessee.
Feb. 14-17	Mid-South Postgraduate Medical Assembly, Memphis, Tennessee.
Mar. 1	Postgraduate course, Management of the Psychiatric Patient in Daily Practice, Vanderbilt University, Nashville, Tennessee.
Mar. 2-3	Postgraduate Course, Selected Topics in Internal Medicine, University of Virginia, Charlottesville, Virginia.
Mar. 5	Postgraduate Course, Ophthalmology, Ohio State University, Columbus, Ohio.
Mar. 5-7	American College of Surgeons Sectional, Sheraton Cadillac, Detroit, Michigan.
Mar. 7-8	Indiana Academy of General Practice, French Lick, Indiana.
Mar. 18-21	Missouri State Medical Association, St. Louis, Missouri.
Mar. 22	Postgraduate Course, Common Pediatric Surgical Problems, Vanderbilt University, Nashville, Tennessee.
Mar. 26-28	American College of Surgeons, Memphis, Tennessee.

Information concerning postgraduate opportunities in other areas of the country may be obtained by contacting the KSMA Postgraduate Medical Education Office, 104 West Chestnut Street, Louisville 2, Kentucky.

Dr. Denham On New Committee

Mitchell B. Denham, M.D., Maysville, state representative from the 65th District, has been named by Gov. Bert Combs to the new State Resources, Research and Development Advisory committee. In a recent meeting, the committee recommended an accelerated program of research to uncover new and improved uses for Kentucky's coal and other natural resources.

J. E. Jenkins, M.D., Sebree, a Webster County physician for 50 years, was selected as "Mr. Sebree" at the 13th annual Sebree Fall Festival on October 19.

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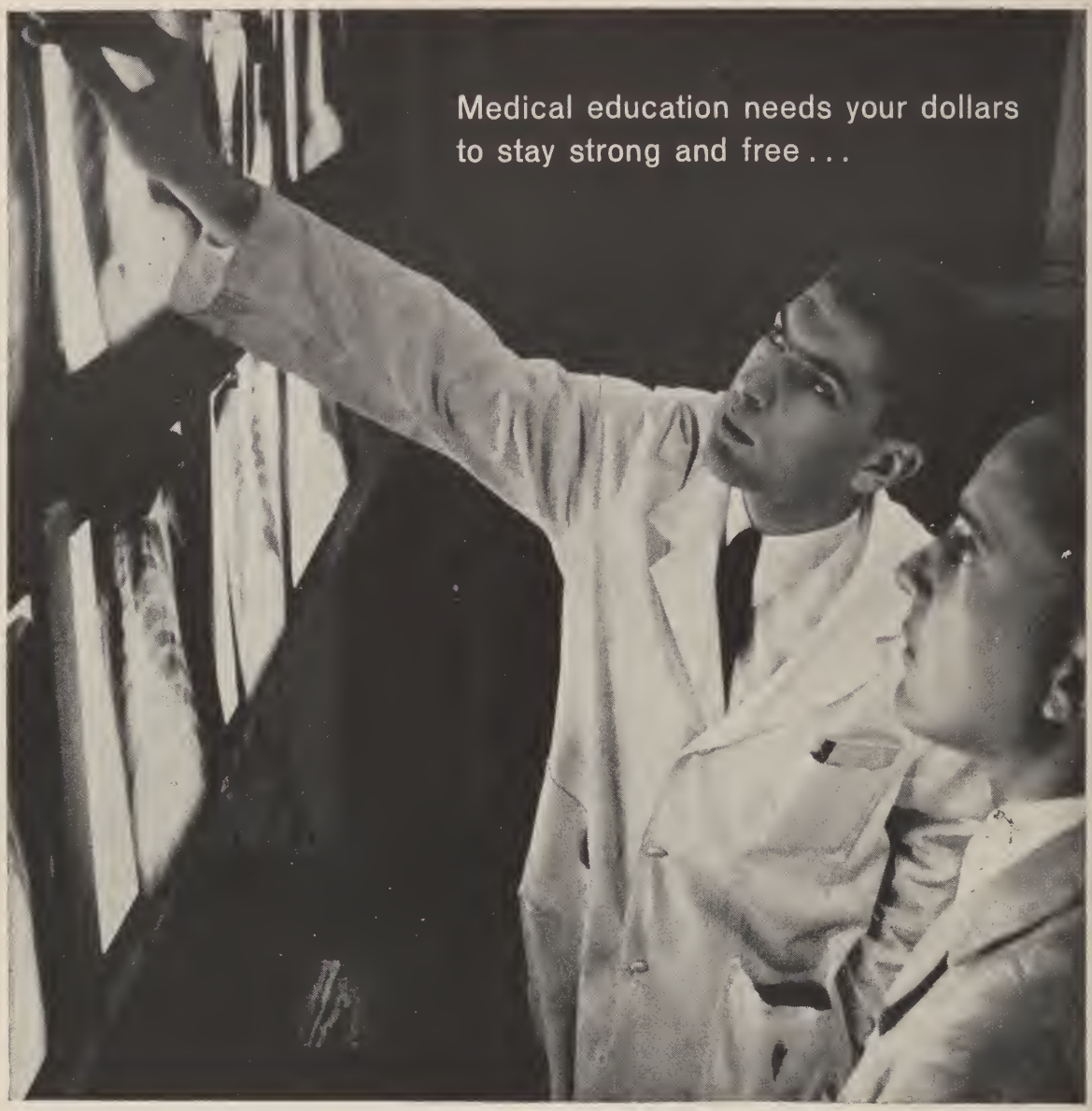
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IN THE BOOKS

HANDBOOK OF SURGERY: by John L. Wilson, M.D., and Joseph J. McDonald, M.D.; published by Lange Medical Publications, Los Altos, Calif.; 644 pages; price $4.00.

This little handbook, with 650 pages, size 7" x 4", is attractively and durably bound in a red plastic-type cover. It is very condensed with a small but clear print. As set forth in its preface, its purpose is to present a concise summary of diagnosis, pre- and post-operative care, complications, etc., but little on technique.

Being stripped to essentials, the presentation of material is didactic without giving much of reason or alternative. However, it appears to be quite up to date, correct and authoritative in its statements. The section on fractures stresses complications and pitfalls in management of apparently innocent breaks.

The book contains numerous tables, charts, diagrams and data simplifications which are very helpful to the reader in quick grasp of material. There is no bibliography and little reference to outstanding authorities, the lack of which seemed to detract somewhat from interest in reading.

The reviewer referred this book for perusal to two of his senior residents and also to Doctor James Hurt, chief of orthopaedic section. All three agreed that the book was up to date, accurate, and helpful as far as it went. One of the residents bought a copy! To summarize, the book is an accurate compendium for quick, ready reference, but is not in any way a text book.

Joseph E. Hamilton, M.D.

HEREDITY IN OPHTHALMOLOGY: by Jules Francois; The C. V. Mosby Company, St. Louis, Mo.; 1961, 731 pages; price, $23.00.

Jules Francois, Professor of Ophthalmology at the University of Ghent, Belgium, and author of HEREDITY IN OPHTHALMOLOGY, has given to the practicing ophthalmologist a very useful book that is not at all removed from his everyday practice. He has prepared for the student of genetics a study of heredity in its everyday clinical applications. He has given to the student of medicine of any age a most fascinating story, proving once again that the pursuit of knowledge is its own reward and that no specialty is alone unto itself.

Hereditary diseases as a primary cause of blindness are ever increasing in importance. Doctor Francois goes into appreciated detail of the hereditary diseases of the eye after a thorough, but terse, discussion of general genetics and genetics in ophthalmology. The last section of the book is devoted to general diseases with ocular manifestations, ranging from alcaptonuria to the xanthomatoses. The everyday, the unusual, as well as the rare, are included.

This work is not just a collection of unrelated and sundry genetic details. It is an excellently illustrated array of modern genetics, clinical ophthalmology, and general medicine, accented with many actual cases gathered from the author's own wide clinical experience. The bibliography is remarkable for its completeness but is predominantly of non-English references.

Edward C. Shrader, M.D.

INSTRUCTIONAL COURSE LECTURES, Vol. XVIII: edited by Fred C. Reynolds, M.D.; published by The C. V. Mosby Company, St. Louis, Mo.; 420 pages; price, $18.50.

This book is a summary of articles written by the "Instructors" who give instructional courses each year at the American Academy Meetings. The 1960 volume is the 17th Instructional Course Volume.

These books are very valuable reference works for the orthopaedic surgeon's library. They represent articles written by men who are specialists, within the field of the specialty of orthopaedic surgery. Some of the subjects covered are as follows:

"Fractures of the Elbow in Children," an excellent article on this subject that should be read by every orthopaedic surgeon and orthopaedic resident; "Diagnosis of Arterial Injury in the Extremities;" "Surgical Management of Vascular Injuries Associated With Long Bone Fracture;" a Symposium on Bone Graft Surgery; and a Symposium on Athletic Injuries.

Richard T. Hudson, M.D.

What They Said About The 1961 KSMA Annual Meeting

May I take this opportunity to express with deepest appreciation your invitation to the Kentucky State Medical Meeting in Louisville. Mrs. Petznick and myself were the recipients of much graciousness and thoughtfulness.

Representing the Ohio State Medical Association was a privilege and I want to express again to you and the Kentucky State Medical Association the thought that the doctors of Ohio are interested in their neighbors and their problems. —George W. Petznick, M.D., president, Ohio State Medical Association

* * *

I want to congratulate you and the Kentucky State Medical Association for the excellent meeting which you held and thank you for allowing me to participate.

I had a most pleasant time during my stay in Louisville. —Jerome F. Wiot, M.D., Cincinnati, Ohio, essayist.

* * *

Thank you for your very kind letter of the twenty-sixth. The meetings were most enjoyable to me. The consideration and courtesy given by the Association members was extraordinary. The whole affair was one which I regret Mrs. Langford could not have enjoyed, too. It was true "Southern Hospitality" and graciousness which I will not soon forget. —William S. Langford, M.D., New York, N.Y., essayist.

Thank you very much for your letter of September 27th. I enjoyed meeting with the Kentucky State Medical Association and am deeply grateful to you for your many courtesies. —Frank Princi, M.D., Cincinnati, Ohio, essayist.

* * *

It was a pleasure to take part in your program and I was pleased to be invited to participate. Everyone with whom I had contact did all he or she could to make my stay in Louisville comfortable and pleasant. —Virgil A. Plessinger, M.D., Cincinnati, Ohio, essayist.

* * *

I certainly enjoyed participating in your excellent program, and I found Louisville to be a wonderful city. Everyone was most hospitable. —George F. Rumer, Lt. Colonel, MC, Fort Sam Houston, Texas, essayist.

* * *

We wish to thank the Kentucky State Medical Association for the many kindnesses extended during our recent trip to Louisville. We enjoyed the meeting to the utmost and are only sorry that we could not stay longer. —Conrad G. Collins, M.D., New Orleans, Louisiana, essayist.

The Gill Memorial Eye, Ear and Throat Hospital will hold its 35th annual Spring Congress in ophthalmology, otolaryngology, and allied specialties April 2-6, 1962, in Roanoke, Va. For further information, write Superintendent, P.O. Box 1789, Roanoke, Va.

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County Society Reports
McCracken County

The monthly meeting of the society was held on September 13 with Joe B. Spaulding, M.D., Paducah, vice president, presiding. Gaithel L. Simpson, M.D., Greenville, discussed "The Kerr-Mills Bill in Kentucky," and Mr. Richard Kilborn, executive vice president of Indiana Blue Shield, described the Indiana Blue Shield Plan.

The Indiana Plan was discussed at length by Society members. The Society went on record as favoring it, but left its delegates free to make their own decisions at the House of Delegates sessions during the KSMA Annual Meeting.

College of Allergists To Meet

The American College of Allergists announces that it will hold a graduate instructional course and its Eighteenth Annual Congress April 1-6, 1962. The meetings will be held at the Hotel Radisson, Minneapolis, Minnesota. For further information, write John D. Gillespie, M.D., Treasurer, 2141 14th Street, Boulder, Colorado.

Surgical Congress To Meet

According to J. Duffy Hancock, M.D., Louisville, general chairman, the Southeastern Surgical Congress will be held in Louisville, March 5-8, at the Brown Hotel. Mrs. C. Melvin Bernhard, Louisville, is chairman of women's activities for the meeting.

Ira O. Wallace Joins State Health Department

Ira O. Wallace, New Castle, has joined the Kentucky State Department of Health as consultant in nursing home administration in connection with the Nursing Home Staff Training Program of the Division of Chronic Disease Control.

Mr. Wallace was a founder and first president of the Kentucky Nursing Homes Association and has been active on the Kentucky Rural Health Council. He is presently a member of the Governor's Commission on Aging and chairman of its committee on housing and living arrangements.

The Nursing Home Staff Training Program was initiated in Kentucky last year. Mr. Wallace's duties with it will include providing assistance to nursing homes in preparing for the possibility of inclusion in the State's Medcal Care Program and in problems of housing and arrangement of homes, as well as general consultation in administration.

80 Attend Fall Conference

Approximately 80 physicians attended the Sixth Annual Fall Clinical Conference co-sponsored by the Lexington Clinic and the Kentucky Academy of General Practice.

The Conference was held at the Clinic Building and the Campbell House in Lexington on October 27. It was approved for six hours of Category I Credit by the AAGP.



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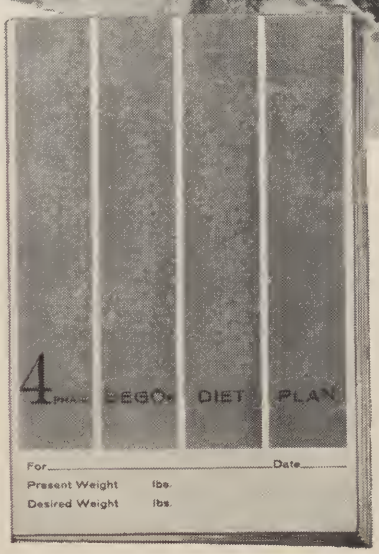
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From the files of the COMMITTEE FOR THE STUDY OF MATERNAL MORTALITY



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	Month of Pregancy											
	1	2	3	4	5	6	7	8	9			
									1	2	3	4
BP			116	116	122	112	110	104	114			
			70	70	80	66	70	66	72			
Weight			132	134½	138	141	142	147	150			
Urine			neg.	neg.	neg.	neg.	neg.	neg.	neg.			
VDRL non-reactive				Rh+		HB 86%						

The patient's past history is significant. After having three vaginal deliveries she had placenta previa in 1947 and was sectioned. She had a repeat section in 1949.

10-29-50: The patient had her third repeat section. The uterine wall was described as "very thin" the incision was through the lower third.

6-22-52: After the fourth section the operative note described a thin area on the anterior surface of the fundus, which could be palpated through the abdomen and the fetal parts were very prominent here. This section was a low cervical type; the longitudinal incision was carried up and the old scar was excised.

8-26-54: At the time of the fifth repeat section a low cervical incision was made. A thin area about one inch in width and three inches long was noted in the region of the fundus, the result of a classical operation where the first section was performed.

3-27-56: The patient had a spontaneous AB at 2½ months.

6-6-57: She had her sixth repeat section and again the surgeon described excising the thin area in the fundus of the uterus.

7-28-60: The patient was at term. At 3:00 p.m. she complained of some abdominal pain and called her family physician. She was rushed to the hospital, where she had delivered before, and had no detectable pulse or blood pressure when she arrived at the emergency room at 1:23 a.m. A laporatomy was performed and a 9 lb. 3 oz. stillborn male infant was delivered by enlarging the spontaneous rupture of the uterus in the lower segment that was about four inches long and was in the area of a previous incision. The abdomen contained approximately 3000 cc of blood.

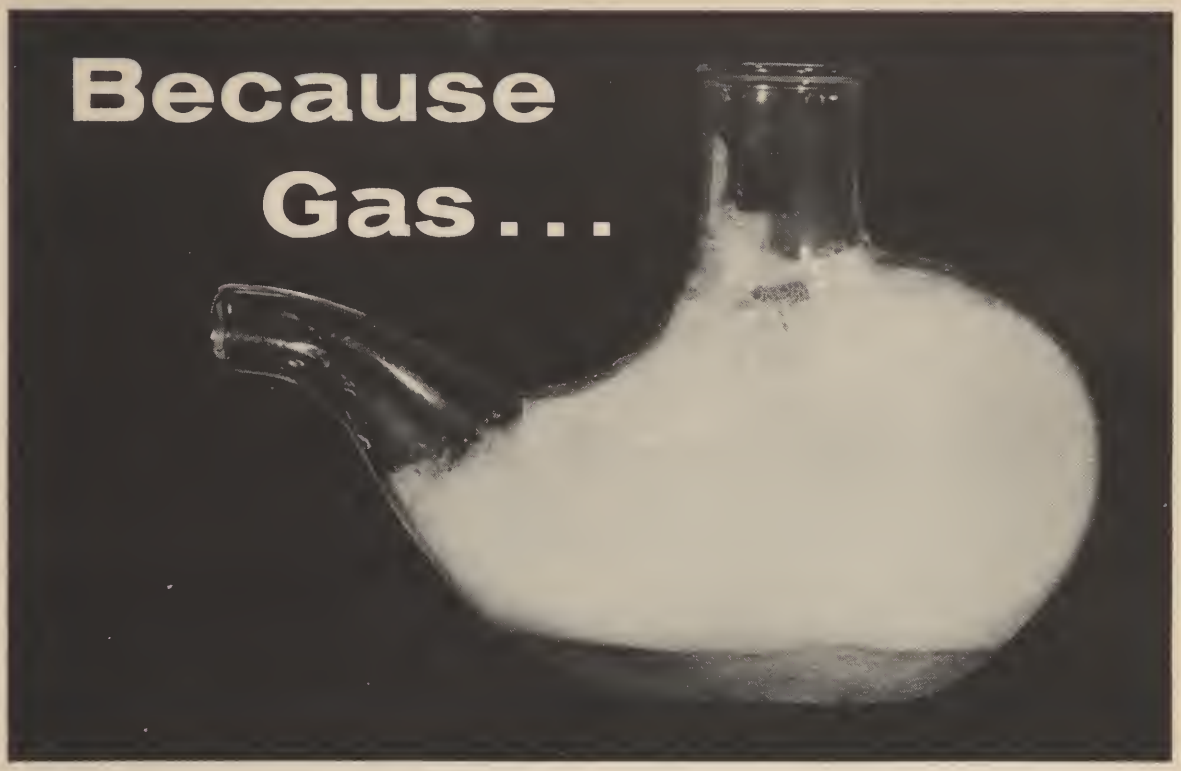
The cause of death was rupture of a pregnant uterus, due in part to six previous cesarean sections. There was no official autopsy, however, the cause of death was established through the post mortem section.

Comments

The committee considered this a direct obstetrical death with possible preventable factors. The patient having had this number of repeat sections with the persistent finding at surgery of the thinning described, should have made arrangements to live close to the hospital or be able to get there in short order if she had any abdominal pain. The size of the infant in this case would have allowed it to have been delivered safely two weeks earlier. However, this is a problem with repeat section in losing infants from prematurity as it can't be taken as a rule of thumb.

The uterine scar of a previous cesarean section remains the largest single predisposing factor to spontaneous rupture. This case demonstrates that the type of the previous section appears to have no bearing on the likelihood of rupture whether before labor or during labor. Recent reviews also note the incident of rupture of the transverse low cervical incision appears to be about the same as that for the longitudinal incision.

Rupture of the gravid uterus is still one of the most serious catastrophies in obstetrics. Despite modern therapy, the maternal mortality associated with this accident remains high.



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When peptic ulcer, hyperacidity and heartburn are complicated by gas, they require more than antacids . . . *they require Silain-Gel!*

Silain-Gel includes a defrothicant, methylpolysiloxane*, that breaks up frothy bubbles thus liberating gas for elimination. And Silain-Gel includes the properly balanced antacid formulation for maximum neutralization.

Patient acceptance is assured by the non-fatiguing fruit mint taste of Silain-Gel. Silain-Gel is safe for long-term administration.

Dosage: Silain-Gel Liquid—2 teaspoonfuls 4 times daily after or between meals and at bedtime. Silain-Gel Tablets—2 tablets (chewed or swallowed) after meals and at bedtime.

Formula: Each tablet contains 25 mg. activated methylpolysiloxane, 282 mg. aluminum hydroxide (equivalent to Dried Gel, U.S.P.) and 85 mg. magnesium hydroxide. Each teaspoonful of Liquid is equivalent to 1 tablet.

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Answers To Questions About Your

BLUE SHIELD

Q.—Is medicare a Blue Shield Program?

A.—No. The Kentucky State Medical Association has a contract with the government for eligible dependents of Service Personnel and Blue Shield is the fiscal agent for the association.

Q.—What is meant by "community rating" for group prepayment plans?

A.—Community rating is the principle followed by Blue Shield that all members should share equally in the expense of health protection. Rates are based on the experience of the members in Kentucky. Everyone is charged the same dues for the same benefits. Under this community approach, the individual or group requiring a greater degree of care does not have to bear a heavier financial burden, because the cost is spread evenly among the entire membership.

Experience rating as practiced by commercial insurance means that a group's rate increases according to its utilization. Each group must stand upon its own experience regardless of how prohibitive the rate may become; also, underwriting requirements are set up that generally exclude retirees, people leaving the group, and children who become of age.

Q.—Why is it necessary to complete separate Blue Shield service reports for each service rendered?

A.—It aids in making faster and proper payments to doctors.

Q.—How many members does Kentucky Physicians Mutual now have in Kentucky?

A.—As of August 31, 1961 there were over 722,000 Kentuckians enrolled in the Plan. This is a remarkable growth since Blue Shield was started in 1949. There are hundreds of Kentuckians enrolled in the Blue Shield Plans of Ohio, Indiana, Tennessee, because of their employment in these states.

Q.—What is the 1960 Blue Shield record of payment to doctors?

A.—Here is the record:

1. Paid to doctors in 1960 for services to members, $6,125,485.36.
2. Increase in 1960 over 1959: $1,084,151.11.
3. 48.29% of amount paid was for surgery done in hospital.
4. 51.71% of amount paid was for office or home surgery, obstetrical, in-hospital medical, x-rays, anesthesia, and radium therapy.

Q.—Why are doctors asked to sign Participating Physicians Agreements and what does Paragraph 3—Section IV of the Blue Shield Certificate of Membership mean? It states: "Services by Non-Participating Doctors of Medicine . . . ." The member is entitled to a Doctor of Medicine of his own choice. However, should he have those services listed under Paragraph 2 above performed by a Doctor of Medicine within the state who is not a participating physician, he agrees that Kentucky Physicians Mutual, Inc., may reimburse such Doctor according to the fee schedule herein, except in any accounting period, it may be necessary to reduce such fees by 25% in accordance with the Agreement with Participating Physicians. The non-participating physician shall submit on the Standard form within 30 days proof of service rendered to Kentucky Physicians Mutual, Inc. and also that he is a Doctor of Medicine licensed to practice under Chapter 311 Kentucky Revised Statues, 1946, or under similar chapters in codes of other states.

A.—Blue Shield, as the Plan organized by the State Medical Association, needs the support of doctors to properly fulfill its purpose. It is important that the economic control of medicine be held by the medical profession. Blue Shield in its first years of operation needed the Participating Physicians Agreements for financial strength, and these agreements still make the plan financially stronger. The Board of Trustees reserves the right not to promote enrollment in a county where 51% of the doctors have not signed the Participating Physicians Agreement.

It is unlikely that Kentucky Physicians Mutual would ever have to prorate its payments to doctors, because the organization has adequate reserves, and would now have sufficient time to adjust subscriber dues long before these reserves were depleted.

Participating Physicians also receive all current information about Blue Shield.

Paragraph 3—Section IV means that should it ever become necessary to prorate payments to participating physicians, payments to non-participating physicians prior to that time would be reduced by 25%. This could be considerably in excess of the reduction to participating physicians, and participating physicians would subsequently be the first ones repaid for any proration made.

New TB Officer Joins State

M. Stuart Lauder, M.D., C.M., has accepted an appointment to the Kentucky State Department of Health as Director of Tuberculosis Control. Doctor Lauder, a native of Chapleau, Ontario, and a graduate of Queen's University, Kingston, Ontario, has been Acting Superintendent of the Royal Ottawa Sanatorium.

He has worked with tuberculosis control for 21 years. In 1942, he assisted with one of the first mass tuberculosis surveys done in North America in the province of Sasketchewan. Doctor Lauder has also been Director of Tuberculosis Control for the City of Ottawa, and Director of the Chest Clinic there. Other experience includes a year as Assistant Director of Tuberculosis Control in West Virginia.

Mr. Donohue Resigns AMA Post

Stephen T. Donohue, who joined the AMA staff in 1950, has announced his resignation to form The Stephen T. Donohue Company. Mr. Donohue began his work with the AMA as Assistant Director of Public Relations and has been Director of Media Relations since 1958. He was also Assistant to the Communications Division Director, Leo E. Brown.

The new company is a public relations counseling organization specializing in the medical and health fields. It will work primarily as communications and public relations consultants to physicians organizations. According to Mr. Donohue, offices are located at 420 Lexington Avenue in New York City.

Case Discussion

(Continued from page 1181)

due to chronic gingivitis secondary to poor oral care. Careful and complete examination excluded the presence of cancer. His mandibular motion and bite approached normal. The lateral deviation of the mandible was much less than we expected and was so minimal that it was almost undetectable and in no way interfered with the functional results.

The patient's facial palsy is most surely temporary and due to stretching and pressure on the nerve during the operation.

This procedure thus satisfactorily produced a good functional result as well as making possible the determination of the etiology, and the correction of, the intraoral pathology.

A 1959 graduate of the University of Louisville School of Medicine, **Kenneth P. Levison, M.D.,** has opened an office in Louisville for general practice. Doctor Levison, a native of Yazoo City, Miss., interned at General Rose Memorial Hospital, Denver, Colo. He served as a captain in the U. S. Army from 1952-54.

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In Memoriam

LEO BLOCH, M.D.
Louisville
1875-1961

Leo Bloch, M.D., who received his medical degree from the University of Louisville in 1899, died November 4 at his home in Louisville. Doctor Bloch, 86, was past staff president of Jewish and SS. Mary and Elizabeth hospitals and was a staff member of Kentucky Baptist Hospital and St. Joseph Infirmary. He was retired and had been in ill health for about a year.

LLOYD SIMPSON, M.D.
Paducah
1884-1961

Lloyd Simpson, M.D., a practicing physician in the Paducah area for 51 years, died November 15 at Western Baptist Hospital after a week's illness. For the last 38 years, Doctor Simpson maintained his office at Lowes, Graves County.

He was a native of Milburn, Carlisle County, and received his medical degree from the Eclectic Medical Institute in 1909.

HENRY G. FOUSHEE, M.D.
Lexington
1883-1961

A Lexington physician for 28 years, Henry Gilbert Foushee, M.D., died October 25 after a two-year illness. A Lexington native, Doctor Foushee was a 1906 graduate of the University of Louisville School of Medicine. He interned at the St. Joseph Hospital, Lexington, and practiced in that city from 1912 to 1940.

SAMUEL J. BROWNSTEIN, M.D.
Louisville
1886-1961

Samuel J. Brownstein, M.D., chief medical examiner for the Louisville Police and Fire departments, died October 28 at Jewish Hospital. Doctor Brownstein, 74, had previously been with the City-County Health Department for about 20 years. He received his medical degree from the University of Louisville in 1908.

GEORGE H. WHITE, M.D.
Crestwood
1881-1961

A Louisville physician for more than 50 years until his retirement five years ago, George H. White, Sr., M.D., died October 23 at Pewee Valley Hospital in Oldham County. Doctor White, a Louisville native, received his medical degree from the old Kentucky School of Medicine in 1903. He was 81 and lived in Crestwood.

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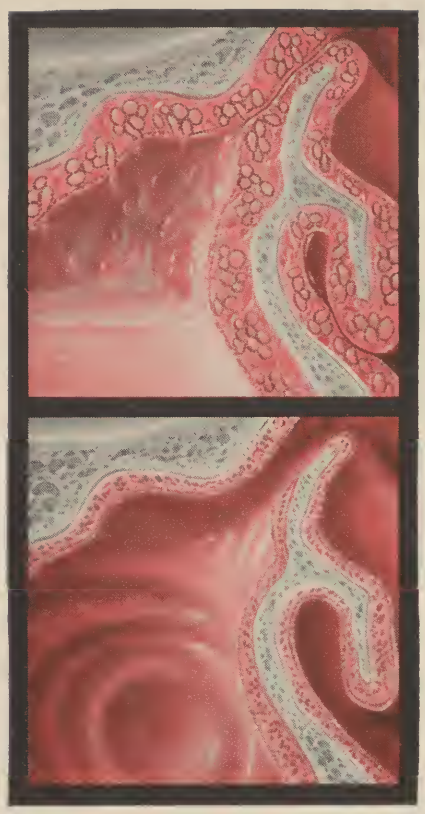
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PUBLIC HEALTH PAGE

The Reiter Protein Complement Fixation Test*

RUSSELL E. TEAGUE, M.D., M.P.H. *Commissioner of Health, Commonwealth of Kentucky*

THE patient who presents definite early or late manifestations of syphilis offers no problem in diagnosis and treatment to an alert and observant physician. Rather it is the patient with no history and no physical or epidemiologic evidence of the disease who presents one of the most arduous and time-consuming diagnostic problems to his physician. The diagnostic problem of syphilitic infection versus biologic false positive reactor is one which requires the physician to utilize all the tools of his diagnostic armamentarium and above all this requires or presupposes his complete understanding of the various serologic tests for syphilis which in this modern age are becoming more complex by the day.

Therefore, as a step in providing our physicians with the latest in serologic tests for syphilis, we are announcing the availability of the Reiter Protein Complement Fixation test (RPCF) in the laboratories of the State Health Department. In order for this test to be correctly utilized, there are certain principles and facts surrounding the Reiter Protein Complement Fixation test which must be understood and constantly borne in mind if the test is to serve its greatest function without misleading the physician.

The current serologic tests for syphilis are of two general types: (1) those which detect the presence of a substance called "reagin" by the use of a non-treponemal antigen, (Kahn, Kolmer, VDRL) and (2) those which employ specific treponemal antigen, (Treponema Pallidum Immobilization, Fluorescent Treponemal Antibody, Treponema Pallidum Complement Fixation, Reiter Protein Complement Fixation). It is obvious that in the non-treponemal tests, which employ the use of a cardiolipin substance to detect the presence of reagin, there can be no distinct advantage to a physician confronted with a reactive VDRL to obtain a Kolmer Complement Fixation test. Since both tests react to reagin, they merely serve as a check on one another but cannot aid in differentiating a false positive result.

The newer treponemal tests, in particular the Reiter Protein Complement Fixation test, have been devised in order to clarify or distinguish a true reactive from a false positive result obtained from a reagin test. The RPCF utilizes as an antigen a protein extract of the avirulent, cultivatable Reiter strain of Treponema pallidum. This antigen has been demonstrated to be both immunologically and serologically similar to that of the virulent strain of Treponema pallidum. Hence one can utilize the material in testing for the antibodies produced by the virulent strain of Treponema pallidum. The Reiter Protein Complement Fixation is performed using this Reiter protein antigen.

In order to better understand the results obtained from this test, it is important to realize several points. In a preliminary study in 1957, the Reiter Protein Complement Fixation test demonstrated a relative specificity of 98.8% in comparison with the Treponema Pallidum Immobilization (TPI) and Treponema Pallidum Complement Fixation (TPCF) and a similar percentage of overall sensitivity with the Treponema Pallidum Complement Fixation test. Comparison of the RPCF with other serologic tests for syphilis in regard to its sensitivity (ability to be reactive in the presence of syphilis) and specificity (ability to be non-reactive in the absence of syphilis) has not yet been evaluated sufficiently to determine comparative performance in different stages of syphilis. However, preliminary observations indicate a high degree of specificity but a lower sensitivity compared to the TPI, giving an overall agreement of not more than 80 per cent with the TPI. These studies showed good correlation between these two tests on serums from patients with no history of syphilis but with weakly reactive or reactive VDRL and cardiolipin Kolmer tests.

This article was prepared by Philip J. Maloney, M.D., Director of Veneral Disease Control, Louisville-Jefferson County Health Department.

It should be noted that since the different serologic tests for syphilis detect different immunologic responses, the appearance of the different specific antibodies detected by each test accordingly appear at different time intervals. Hence at any one time a marked apparent discrepancy could be noted between a VDRL Treponema Pollidum Complement Fixation test, Reiter Protein Complement Fixation test, and Treponema Pallidum Immobilization test. It is toward such possible discrepancy that I wish to devote special attention.

Since the Reiter Protein Complement Fixation may revert to a non-reactive pattern following treatment, it is imperative to realize that a non-reactive Reiter Protein Complement Fixation test may be interpreted in one of three ways: (1) non-syphilitic (2) recently acquired and untreated syphilis (3) adequately treated early or late syphilis. The acceptance of a reactive or weakly reactive Reiter Protein Complement Fixation test as evidence of present or past syphilis has been well established. But the finding of some syphilitic patients with non-reactive Reiter Protein Complement Fixation and reactive Treponema Pallidum Immobilization tests indicates the continued need for use of the Treponema Pallidum Immobilization as a confirmatory procedure on serum non-reactive with the Reiter Protein Complement Fixation test. Therefore it is recommended that reactive or weakly reactive serums to the VDRL test in patients without any history or physical evidence of syphilis, be subjected to the Reiter Protein Complement Fixation test. *When this result is reactive or weakly reactive, past or present syphilis is evidenced.* All non-reactive serums to the Reiter Protein Complement Fixation test should be subjected to the Treponema Pallidum Immobilization tests if further diagnostic evidence is desired. It cannot be stressed too greatly that a *non-reactive Reiter Protein Complement Fixation test does not rule out past or present syphilitic infection.*

We must however remember that the availability of these tests on a no-cost basis does not mean that each patient suspected of having syphilis should be subjected to such testing. Rather the Reiter Protein Complement Fixation test should be reserved for use in the difficult differentiation of the chronic biologic false positive reaction from the syphilis patient. Nor do any of these tests serve in place of a careful and complete history and physical examination. Unless a physician acquires sufficient knowledge to properly interpret the test results in relation to the status of his patient, he simply cannot correctly interpret the apparent contradictory and confusing findings between treponemal and non-treponemal tests. Without such knowledge, the physician is unlikely to realize the special limitations of these tests and hence will fail to obtain the proper test at the proper time.

In summary therefore, I have attempted to review the basic foundations for serologic tests for syphilis and especially to review the origin and *interpretation* of the Reiter Protein Complement Fixation test. Although public health control of the rapidly rising problem of infectious syphilis depends on accurate serodiagnostic methods, we must not lose sight of latent or late syphilis or the exclusion of degenerative disease causing biologic false positive reactions. It is toward this aim that the proper use of the Reiter Protein Complement Fixation test is advocated.

Washington News

(Continued from Page 1154)

concert, and follow the same radiation protection standards, through the coordinating influence of the Federal Radiation Council. . .

Supplementing these Federal programs and resources is a steadily increasing radiological health capability among State and large city governments. Their programs are usually centered in the departments of public health, with certain special responsibilities often located in other agencies such as State or city departments of public safety. At every level of government, resources and programs are being expanded to cope with the potentially hazardous situation the nation now faces.

Pulmonary Sarcoidosis

(Continued from Page 1167)

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NEWS ITEMS

William B. Triplett, M.D., is closing his practice of internal medicine in Owensboro to join the department of allergy and allergy research at the Ohio State University School of Medicine, Columbus, Ohio. Doctor Triplett has practiced in Owensboro for four years. He received his medical degree from the University of Louisville in 1953 and took three years of residency training at the Louisville V.A. Hospital.

Carlisle Morse, M.D., Louisville, has been reappointed Governor of the State of Kentucky for the American Diabetes Association. Blair Holcomb, M.D., president of the Association, announces that Doctor Morse will serve a three-year term.

Milton Comer, M.D., has opened an office for the practice of general surgery in Louisville. Doctor Comer, a 1954 graduate of the University of Louisville School of Medicine, took his internship at Denver General Hospital and residency training at the Roosevelt Hospital, New York. He served for two years in the U. S. Army Medical Corps with the rank of captain.

Dallas C. Hagg, M.D., a 1956 graduate of the University of Louisville School of Medicine, has begun the practice of general surgery in Frankfort. Doctor Hagg interned at City Hospital, Springfield, Ohio, and took residency training at the Veterans Administration Hospital, Louisville.

Robert F. Bettasso, M. D., has joined the **Trover Clinic,** Madisonville, where he limits his practice to general surgery. Doctor Bettasso received his medical degree from Illinois University in 1956 and interned at Illinois Central Hospital. He took residency training at Hines Veterans Hospital, Hines, Ill. Doctor Bettasso served for two years with the U.S. Army with the rank of sergeant.
Organization

Donald B. Thurber, M.D., has taken a new position with the experimental station of E. I. du Pont de Nemours and Company, Wilmington, Delaware. Doctor Thurber was previously with the General Electric Company in Louisville.

Walter Mason, M.D., has been appointed to the staff of the Middlesboro Memorial Hospital as a general practitioner. Doctor Mason, a native of Memphis. Tenn., was a U. S. Navy flight surgeon before coming to Middlesboro. He received his medical degree from the University of Tennessee.

Henry L. Gragg, M.D., Junction City, was one of 49 physicians recently honored by the University of Tennessee Medical Units. Doctor Gragg received his medical degree in 1911 from the old Medical Department of Lincoln Memorial University in Knoxville, which was consolidated with the University of Tennessee College of Medicine in 1914.

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Pertinent Paragraphs

A postgraduate course in laryngology and bronchoesophagology will be held by the Department of Otolaryngology, University of Illinois College of Medicine April 2 through 14, 1962. Instruction will be by means of animal demonstrations and practice in bronchoscopy and esophagoscopy, diagnostic and surgical clinics, as well as didactic lectures. Registration will be limited to fifteen physicians. For further information and registration, write to the Department of Otolaryngology, University of Illinois College of Medicine, 1853 West Polk Street, Chicago 12, Illinois.

The Cystic Fibrosis Training and Research Center of Cincinnati has available for the medical profession a film dealing with diagnosis, therapy, and pathology of cystic fibrosis. To borrow the film, write M. Saidleman, M.D., Assistant Director of the Center, in care of The Convalescent Hospital for Children, Auburn and Wellington, Cincinnati 19, Ohio.

The 26th Annual Session of the International Medical Assembly of Southwest Texas will be held in San Antonio, Texas, January 29-31, 1962, at the Granada Hotel. There will be 17 scientific speakers plus many social events for the physician and his wife. For further information, write Lawrence B. Reppert, M.D., President, or Mr. S. E. Cockrell, Jr., Executive Secretary, 202 West French Place, San Antonio 12, Texas.

Luther L. Terry, M.D., Surgeon General of the Public Health Service, announces the award of 48 grants totaling $14,575,628. The grants are to help build and equip additional health research facilities in 40 institutions in 23 states. The construction program of the Health Research Facilities is designed to expand and improve the Nation's facilities for medical research.

Let me recall to your mind a series of headlines con-cerning fantastic "markups." One such set of headlines charged a 7000% markup *over the ingredient cost* of one Schering Corporation drug! . . . I can tell you that we at Baxter have a product with a far more astronomic markup *over the ingredient cost* than anything the (Kefauver) committee released for the front pages. One of our ingredients has a markup of more than half a million per cent—675,000% to be exact. That ingredient is water . . . Actually, this fabulous markup gives us a sales profit of 7.1%. We are not selling the ingredient. You can get that out of a faucet. We are selling injectable distilled water which will not cause a fever when introduced into the blood stream.—William B. Graham, President, Baxter Laboratories, Inc., to the Investment Analysts Society of Chicago.

Over the past 20 or 30 years medical contributions to the health and welfare of our people through careful research have been magnificent. That this is true is clearly evidenced by the fact that miracle drugs, lifesaving vaccines and new types of equipment have become household words even for the man of the street.—Charles S. Rhyne, former president, American Bar Association.

The Pentagon has ordered the draft of 816 doctors, dentists, and veterinarians in the buildup of the Army, Navy and Air Force. The Defense Department has asked Selective Service to call 495 doctors—275 for the Army, 150 for the Air Force, and 70 for the Navy. The Army will also get 154 dentists and 67 veterinarians. The Pentagon also called up 185 physicians in June, for the Navy and the Air Force because there had not been enough volunteers. Previously, doctors had not been drafted since 1957.

All American industry has contributed, but I must give a special vote of thanks to the pharmaceutical industry, which has contributed in excess of $1 million in cash and drugs to our effort. I have no idea how many other foundations like our own are able to carry on their work because of this great industy, but because this industry has a heart, this award belongs as much to them as it does to me.—William B. Walsh, M.D., founder of Project HOPE, on receiving Fourth Annual Health U. S. A. Award.

I am convinced, in essence, that there should be no changes in any laws which would throttle the development and marketing of valuable new drugs or would curtail the economic incentives that spur our progress. Unless such stifling proposals are intelligently and vigorously opposed and defeated, the drug industry, as it exists today, will vanish as a free and private industry.—Elmer B. Vliet, Chairman of the Board, Abbot Laboratories, to American Society of Oral Surgeons.



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Filmtab coatings replace sugar coatings. This means that our vitamin tablets are quite a bit smaller than most—sometimes by as much as 30%. This makes them easier to swallow. And, because there's no bulk (not even sub-seals are needed) the nutrients are readily available. Yet, patients remain protected from vitamin odors and after-tastes.

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Filmtab coatings don't require water. Consequently, there is virtually no chance of moisture degradation. The potency your patient pays for stays in the tablet. Without sugar, we've even been able to eliminate much of the brittleness. So, tablets are less apt to chip or break.

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Her position on nutrition
Is taught in all the schools.
She's an oracle for others,
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While a mine of diet knowledge
(And, each lecture is a gem)
Poor Ramona from Pomona needs
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Likes, dislikes, and time schedules never interfere with her lectures, doctor, just her diet. She could live in a grocery store and still eat poorly. While Dayalets-M can't replace self-discipline, it can help insure optimal nutrition. Tablets are tiny, potent, and Filmtab-coated. Patients like taking them.

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News Items

Kenneth C. Tufts, M.D., has begun the practice of internal medicine in association with the Lexington Clinic. A 1956 graduate of the Ohio State University Medical School, Doctor Tufts took his internship and residency at University Hospital, Columbus, Ohio. He served in the Medical Corps of the U. S. Army from 1951-52.

John E. Dawson, M.D., a Newport physician and surgeon, has been elected grand junior warden of the Masonic Grand Lodge of Kentucky. His election which places him in line to become grand master in 1964, took place at the 161st annual convention of the grand lodge in Louisville on October 18.

Sandford Logan Weiler, M.D., has begun general practice in Frankfort, having previously practiced in Harlan. A 1951 graduate of the University of Louisville School of Medicine, Doctor Weiler interned at Gloeckner-Penrose Hospital, Colorado Springs, Colo. He served for three years in the U. S. Air Force with the rank of first lieutenant.

Kenneth B. Moore, M.D., is presently associate chief of staff of the Veterans Administration Hospital, Lexington. He was previously assistant medical director of Ypsilanti State Hospital, Ypsilanti, Mich. A native of Pratt, Kansas, Doctor Moore is a 1947 graduate of the University of Kansas Medical School. He interned at the University of Michigan Hospital and took residency training at the Neuropsychiatric Institute of the University of Michigan and at Ypsilanti State Hospital. He served from 1953-55 as a captain in the U. S. Air Force.

New KSMA Members Listed

New members who have joined the KSMA since the last report in The Journal are:

John M. Hall, M.D., Scottsville
Stanley Hadley, Jr., M.D., Lexington
J. T. Reeves, M.D., Lexington
Kenneth Tufts, M.D., Lexington
Harry M. McCormick, M.D., Harlan
Stiles W. Allen, M.D., Louisville
Edwin Carnes, M.D., Louisville
Abraham Rosenstein, M.D., Louisville
Charles Smith, M.D., Louisville

Pertinent Paragraphs

Prints of "The Next Step," a medical motion picture are available for physicians, public health groups, nurses and pharmacists. Premiered at the 1961 Annual Meeting of the American Medical Association in New York, this 16 mm. black and white, sound motion picture presents detailed information on the development, manufacture, testing, immunization properties, and methods used in clinical dispensing of the new live, oral poliovirus vaccine. For further information and film reservation, write Pfizer Laboratories, Div., Chas. Pfizer and Co., Inc., 235 East 42 Street, New York 17, N. Y.

High school students who hope to become doctors can get "on-the-job-training" by working as part-time hospital employees, according to a report in *The Modern Hospital.* Memorial Hospital, North Conway, N. H., chose high school boys with the highest recommendation and greatest apparent interest in medicine to take part in its first trainee program. After training, the boys' pay was raised to $1 per hour—the same as that of nurse's aides. "While other persons could have been obtained to fill the job," said Edmund J. McTernan, administrator of the hospital, "It would be hard to match these boys in terms of enthusiasm and interest, which they have transmitted to other staff members."

The Philadelphia County Medical Society has announced establishment of a library of health-education literature for use by the public as well as physicians. Located at the society's building at 301 South 21st Street, Philadelphia, the library will consist of pamphlets and books on all topics dealing with health. Also included will be books on health education and education techniques such as radio and television. Contributions of pamphlets and resource catalogs for the library may be sent to Bette Metzler, Ball Associates Public Relations Agency, 845 N. Broad Street, Philadelphia 23, Pa.

The University of Illinois College of Medicine has been awarded $128,000 for a two-year study and evaluation of its over-all program in medical education by the Commonwealth Fund of New York. A renewal of an original endowment of $112,000, the grant provides for a full-time staff which will enable the administration and faculty to carry out an intensive study of scientific teaching methods, advance instruction in patient care and development of a permanent program of educational research.

Justice Re-written

Sen. Estes Kefauver, chairman of the Senate Anti-trust and Monopoly Subcommittee, opened hearings on his bill to impose new regulations on the drug industry with this statement:

"The need for action stems basically from the fact that, by any test and under any standard, prices and profits in the ethical drug industry are excessive and unreasonable."

Then, having found the defendant guilty and having announced the verdict to the public, the judge began to listen to the testimony.

—AMA News, October 30, 1961

1961 CONSTITUTION AND BYLAWS OF THE KENTUCKY STATE MEDICAL ASSOCIATION

Revised September 20, 1961

CONSTITUTION

Article I. Name of the Association
Article II. Purpose of the Association
Article III. Component Societies
Article IV. Composition and Meetings of the Association
Article V. Officers
Article VI. House of Delegates
Article VII. Districts, Sections and District Societies
Article VIII. Board of Trustees
Article IX. Funds and Expenses
Article X. Referendum
Article XI. The Seal
Article XII. Amendments
Article XIII. Definitions

Article I. Name of Association

The name and title of this organization shall be the Kentucky State Medical Association.

Article II. Purpose of the Association

The purpose of the Association shall be to federate and bring into compact organization the entire medical profession of the State of Kentucky and to unite with similar associations in other states to form the American Medical Association, with a view to the extension of medical knowledge; the advancement of medical science and charity; the evaluation of the standards of medical education; the enactment and enforcement of just medical laws; the promotion of friendly intercourse among physicians and the guarding and fostering of their material interests; the protection of the members thereof against unjust assaults upon their professional care, skill or integrity; and to the enlightenment and direction of public opinion in regard to the great problems of state medicine so that the profession shall become more capable and honorable within itself and more useful to the public in the prevention and cure of disease and in prolonging and adding comfort to life.

Article III. Component Societies

Component societies shall consist of those medical societies which hold charters from this Association.

Article IV. Composition and Meetings of the Association

The Association shall consist of the members of the component societies but the House of Delegates shall have authority to adopt such bylaws regulating the admission and classification of members as it may deem advisable. The Association shall hold an Annual Meeting and such Special Meetings as may be called pursuant to the bylaws.

Article V. Officers

Section 1. The officers of this Association shall be a President, a President-elect, three Vice-Presidents, a Secretary, a Treasurer, a Speaker and Vice-Speaker of the House of Delegates, a Trustee from each District that may be established, and such other officers as may be provided for in the bylaws.

Section 2. The duties and terms of office of all officers of the Association shall be as prescribed in the bylaws.

Section 3. All officers shall serve until their successors have been elected and installed.

Section 4. All officers shall be elected by the House of Delegates at its Regular Session and shall take office on the last day of the Annual Meeting.

Article VI. House of Delegates

Section 1. The House of Delegates shall be the legislative body of the Association and shall have power, by a two-thirds vote of all the delegates present at that session, to adopt bylaws to carry out the provisions of this Constitution and to provide for the government of the Association in any other manner not inconsistent with this Constitution. It shall meet in Regular Session annually during the Annual Meeting of the Association, and may be called into Special Session under such conditions as may be prescribed in the bylaws.

Section 2. Delegates shall be members of and elected by component societies in such manner as may be provided in the bylaws. Officers of the Association, Delegates and Alternate Delegates to the American Medical Association, and the five immediate Past Presidents shall be ex officio members of the House of Delegates and entitled to vote.

Section 3. The House of Delegates shall elect a Speaker and a Vice-Speaker, one of whom shall preside during the meetings of the House of Delegates. The presiding officer shall not be entitled to a vote except in the event of a tie.

Section 4. The House of Delegates shall be the final judge as to the qualification of its members.

Article VII. Districts, Sections and District Societies

The House of Delegates shall divide the state into Districts composed of one or more counties, for administrative purposes. It may also provide for a division of the scientific work of the Association into appropriate Sections, and for the organization of such District Societies, composed exclusively of members of component societies, as will promote the best interests of the profession.

Article VIII. Board of Trustees

The House of Delegates shall make provision in the bylaws for a Board of Trustees composed of one Trustee from each District and such of the other officers of the Association as the House may deem appropriate, which shall be charged with the general direction of the Association's affairs during the interim between meetings of the House. The House may delegate such powers to the Board of Trustees as are not specifically required by this Constitution to be exercised by the House, and may limit the Board's powers to such extent as it may determine to be necessary or desirable. Provided, however, that in no event shall the Board of Trustees have power to commit the Association to any course of action which is contrary to or at variance with any policy established by the House of Delegates.

Article IX. Funds and Expenses

The House of Delegates shall provide funds for meeting the expenses of the Association by such methods and from such sources as it may select, including but not limited to an equal per capita assessment by class of membership, upon each component county society. Funds may be appropriated by the House of Delegates to defray the expenses of the annual session, for publications and for such other purposes as will promote the welfare of the Association and the profession.

Article X. Referendum

The membership of the Association, by written petition signed by not less than 10% of the active

membership, may obtain a referendum on any question pending before the House of Delegates. The Secretary, upon the presentation of such a petition to him shall cause the question to be submitted to the active membership by mail, and if a majority of the active members shall signify its approval or disapproval of a certain policy or course of action with respect to the question thus submitted, the will of the majority shall determine the question and shall be binding upon the House of Delegates and the Association upon certification of the result of the vote by the Secretary to the President and Board of Trustees.

Article XI. The Seal

The Association shall have a common Seal with power to break, change or renew the same at pleasure.

Article XII. Amendments

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the delegates registered at the Regular Session, provided that such amendment shall have been presented in open meeting at the previous regular session, and that it shall have been sent officially to each component county society at least two months before the session at which final action is to be taken.

Article XIII. Definitions

Whenever used in this Constitution, the Articles of Incorporation or the Bylaws—

(a) "County society," "component county society," or "component medical society" means "component society."

(b) "Annual Meeting" means the annual three-day meeting of the Association.

(c) "Scientific Sessions" mean those sessions during the Annual Meeting at which scientific subjects are programmed and discussed.

(d) "Regular Session" means the regular session of the House of Delegates which is held during the Annual Meeting.

(e) "Special Session" means a special, called meeting or session of the House of Delegates.

BYLAWS

Chapter I.	Membership
Chapter II.	Annual and Special Meetings of the Association
Chapter III.	The House of Delegates
Chapter IV.	Election of Officers
Chapter V.	Duties of Officers
Chapter VI.	Board of Trustees
Chapter VII.	Standing Committees and Councils
Chapter VIII.	Assessments and Expenditures
Chapter IX.	Rules of Conduct
Chapter X.	Rules of Order
Chapter XI.	County Societies
Chapter XII.	Amendments

CHAPTER I. MEMBERSHIP

Section 1. A member of this Association must also be a member of one of the component societies and when certified to the Secretary of the Association as a member of a component society, properly classified as to type of membership, and when the dues pertaining to his membership classification have been received by the Secretary of the Association, the name of the member shall be included in the official roster of the Association and he shall be entitled to all the privileges of his class of membership. Provided, however, that members in good standing from other state societies may, if admitted to membership by a component society, be accepted by KSMA for membership without paying dues for the remainder of the calendar year in which the transfer is made. Provided further, that the Board of Trustees shall have power, upon written application, approved annually by the county society of which the applicant is a member, to excuse any member from the payment of dues because of financial hardship.

Section 2. Membership in the Association shall be divided into seven classes, to-wit: Active, Emeritus, Associate, Inactive, Student, Honorary and Special.

(a) Active Members. The active membership of the Association shall consist of the active members of the various component county medical societies. To be eligible for active membership in any component county society, the applicant must be a doctor of medicine of good moral, ethical, and professional standing, who is licensed to practice medicine in Kentucky.

(b) Emeritus Members. Component societies may elect as a member-emeritus any doctor of medicine who is 70 years of age or who has retired from active practice and who has previously maintained active membership in good standing in his own society for twenty years or more. Emeritus members shall have the right to vote but shall not pay dues, hold office or be entitled to the benefits of Chapter VI, Section 9 of these Bylaws. They shall receive the Journal and other publications of the Association.

(c) Associate Members. The associate membership of the Association shall consist of the associate members of the various component county medical societies. To be eligible for associate membership in any component county society, the applicant must be ineligible for active membership and qualify under one or more of the following groups:

(1) Medical officers of the United States Army, Navy, Air Force, Veterans Administration, Public Health Service, or other governmental service while on duty in the State.

(2) Interns, residents or teaching fellows who are doctors of medicine and who have complied with all pertinent regulations of the State Board of Health.

Associate members shall not have the right to vote nor to hold office, but shall receive the Journal and other publications of the Association.

(d) Inactive Members. The inactive membership of the Association shall consist of the inactive members of the various component county societies. Any doctor of medicine licensed to practice medicine in Kentucky who is not engaged in the practice of medicine but who is otherwise eligible for active membership in the Association may be admitted to inactive membership by any component county society. Inactive members shall not have the right to vote nor hold office, but shall receive the Journal and other publications of the Association.

(e) Student Members. Any student in an accredited medical school in Kentucky or any resident of Kentucky who is a student in any accredited medical school in the United States shall be eligible for student membership. Student members shall not have the right to vote nor hold office. They may apply directly to the State Association for membership and be assigned to the county society of their choice. Student members shall receive the Journal of the Association. The membership year for student members shall run from September 1 to August 31 of each year.

(f) Honorary Members. Any physician possessed of scientific attainments who is a member of a constituent state medical association and who has participated in the program of the scientific session and who is not a citizen of Kentucky may by unanimous vote of the House of Delegates be elected to honorary membership. Honorary members shall be entitled to the privileges of the floor in all scientific sessions.

(g) Special Members. Component societies may invite dentists, pharmacists, funeral directors, or other professional persons to become special members. Special members shall have no rights or obligations under these Bylaws, but may be accorded

the privilege of attending and participating in the scientific meetings of the society. Provided, however, that a registration fee may be required of special members who desire to attend the Annual Meeting of the Association.

Section 3. Guests of Honor. Any distinguished physician not a resident of this State may become a guest of honor during any Annual Meeting upon invitation of the Board of Trustees and shall be accorded the privilege of participating in all of the scientific work of that meeting.

Section 4. Except as provided in Chapter VI, Section 4 of these Bylaws, no person who is under sentence of suspension or expulsion from any component society of this Association, shall be entitled to any of the rights or benefits of membership in this Association.

CHAPTER II. ANNUAL AND SPECIAL MEETINGS OF THE ASSOCIATION

Section 1. The Association shall hold its annual and special meetings at such times and places as may be determined by the House of Delegates.

Section 2. The Annual Meeting shall consist of one or more scientific sessions, at least two meetings of the House of Delegates, and such other gatherings as may be authorized by the Board of Trustees. Each scientific session shall be presided over by the President or in his absence or disability or at his request by the President-Elect or one of the vice presidents. The entire time of the scientific sessions, as far as may be, shall be devoted to papers and discussions related to scientific medicine.

Section 3. The name of a physician upon the properly certified roster of members or list of delegates of a component society which has paid its annual assessment, shall be prima facie evidence of his right to register at any meeting of this Association.

Section 4. Each member in attendance at any meeting shall enter his name on the registration book indicating the component society of which he is a member. When his right to membership has been verified by reference to the roster of the society, he shall receive a badge which shall be evidence of his right to all the privileges of membership at that meeting. No member or delegate shall take part in any of the proceedings of any meeting until he has complied with the provisions of this section.

CHAPTER III. THE HOUSE OF DELEGATES

Section 1. The House of Delegates shall meet in Regular Session at the time and place of the Annual Meeting, and shall, insofar as is practicable, fix its hours of meeting so as to give delegates an opportunity to attend the scientific sessions and other proceedings. Provided, however, that if the business interests of the Association and profession require, the Speaker, with the consent of the Board of Trustees, may convene the Regular Session in advance of the Annual Meeting, and the House may remain in session after the final adjournment thereof.

Section 2. The House may be called into Special Session by the President with the approval of the Board of Trustees, and a special session shall be called by the President on the written request of delegates representing fifty or more component societies. The purpose of all special sessions shall be stated in the call, and all business transacted at any such special session shall be germane to the stated purpose.

Section 3. When a special session is called, the Secretary shall mail a notice of the time, place, and purpose of such meeting to the last known address of each delegate at least ten days before such session.

Section 4. The Speaker shall, by virtue of his office, be responsible for making all arrangements for all sessions, regular or special, of the House.

Section 5. In the event a component society is not represented at any meeting of the House, the Speaker shall consult with any officer of the component society who is in attendance and, with the approval of the Credentials Committee, may appoint any active members of such component society who is in attendance, as its alternate delegate. If no officer of such society is present, the Speaker may make the appointment without consultation, but with the approval of the Credentials Committee. All such appointments shall also be subject to the approval of the House.

Section 6. A majority of the registered delegates shall constitute a quorum and all of the meetings of the House shall be open to members of the Association. The House shall have the right to go into executive session whenever in its judgment such action is indicated; except that active members of the Association shall have the right to attend all executive sessions.

Section 7. Each resolution introduced into the House shall be in writing and signed by the author and presented to the Secretary following its introduction. If the author be an individual member, it shall be signed by him. If the author be a group of members, it shall be signed by the authorized spokesman for that group. Immediately after the Delegate has introduced the Resolution, it shall be referred to the proper Reference Committee before action thereon is taken.

Section 8. No new business shall be introduced in the last meeting of the House without unanimous consent, except when presented by the Board of Trustees. All new business so presented shall require the affirmative vote of three-fourths of those delegates present and voting, for adoption.

Section 9. The House shall give diligent attention to and foster the scientific work and spirit of the Association, and shall constantly study and strive to make each Annual Meeting a stepping stone to further ones of higher interest.

Section 10. It shall consider and advise as to the material interests of the profession, and of the public in those important matters wherein the public is dependent upon the profession, and shall use its influence to secure and enforce all proper medical and public health legislation, and to diffuse information in relation thereto.

Section 11. It shall make careful inquiry into the condition of the profession of each county in the State, and shall have authority to adopt such methods as may be deemed most efficient for building up and increasing the interest in such county societies as already exist and for organizing the profession in counties where societies do not exist. It shall especially and systematically endeavor to promote friendly intercourse between physicians of the same locality and shall continue these efforts until every physician in every county of the State who will agree to abide by the constitution, bylaws and other rules and regulations of the Association and the appropriate component society, has been brought under medical society influence.

Section 12. It shall encourage postgraduate work in medical centers as well as home study and research and shall endeavor to have the results of the same utilized and intelligently discussed in the county societies.

Section 13. It shall elect representatives to the House of Delegates of the American Medical Association in accordance with the Constitution and Bylaws of that body.

Section 14. It shall, upon application, provide and issue charters to county societies organized in conformity with the Constitution and Bylaws of this Association.

Section 15. The state shall be divided into the following districts:

No. 1.—Ballard, Calloway, Carlisle, Fulton, Graves, Hickman, Livingston, McCracken, and Marshall.

No. 2—Daviess, Hancock, Henderson, McLean, Ohio, Union, and Webster.

No. 3—Caldwell, Christian, Crittenden, Hopkins, Lyon, Muhlenberg, Todd, and Trigg.

No. 4—Breckinridge, Bullitt, Grayson, Green, Hardin, Hart, Larue, Marion, Meade, Nelson, Taylor, and Washington.

No. 5—Jefferson.

No. 6—Adair, Allen, Barren, Butler, Cumberland, Edmonson, Logan, Metcalf, Monroe, Sipmson, and Warren.

No. 7—Anderson, Carroll, Franklin, Gallatin, Grant, Henry, Oldham, Owen, Shelby, Spencer, and Trimble.

No. 8—Boone, Campbell, and Kenton.

No. 9—Bath, Bourbon, Bracken, Fleming, Harrison, Mason, Nicholas, Pendleton, Scott, and Robertson.

No. 10—Fayette, Jessamine, and Woodford.

No. 11—Clark, Estill, Jackson, Lee, Madison, Menifee, Montgomery, Owsley, Powell, and Wolfe.

No. 12—Boyle, Casey, Clinton, Garrard, Lincoln, McCreary, Mercer, Pulaski, Rockcastle, Russell, and Wayne.

No. 13—Boyd, Carter, Elliott, Greenup, Lawrence, Lewis, Morgan, and Rowan.

No. 14—Breathitt, Floyd, Johnson, Knott, Letcher, Magoffin, Martin, Perry, and Pike.

No. 15—Bell, Clay, Harlan, Knox, Laurel, Leslie, and Whitley.

District meetings may be held as desired, and District Medical Associations may be organized as desired, according to the districts outlined above.

Section 16. It shall have authority to appoint committees for special purposes from among members of the Association who are not members of the House of Delegates and such committees may report to the House of Delegates in person, and may participate in the debate thereon.

Section 17. Except as provided in Chapter VI, Section 5, it shall approve all memorials and resolutions issued in the name of the Association before the same shall become effective.

Section 18. A digest of proceedings of the House of Delegates shall be published in the Journal of the Association.

CHAPTER IV. ELECTION OF OFFICERS

Section 1. The President-Elect and the Vice Presidents shall be elected for a term of one year. The Speaker of the House of Delegates, the Vice-Speaker of the House, the Secretary and the Treasurer shall be elected for terms of three years. The Trustees shall be elected for terms of three years and shall be limited to serving for not more than two consecutive full terms. The terms of the Trustees shall be so arranged that one-third of the terms expire each year, insofar as possible. No member shall be eligible for the office of President, President-Elect, Vice President, Speaker or Vice Speaker of the House of Delegates, or Trustees, who has not been an active member of the Association for at least five years.

Section 2. During the last meeting of the regular session of the House of Delegates, the Speaker of the House of Delegates shall submit to the members of the House of Delegates a list of ten names from which, by ballot, the House of Delegates shall select five members to serve as the nominating committee for the next year. The five names receiving the most votes shall form the committee. The Committee shall select one of its members as chairman at an organization meeting held during the County Society Officers' Conference, or at some other appropriate place designated by the Board of Trustees at least four months before the Annual Meeting. The Committee, in addition to such other meetings as it may choose to hold, shall schedule an open meeting immediately after the close of the first meeting of the House at each Annual Meeting. This open meeting shall be held in the meeting place of the House of Delegates, shall receive broad publicity, and those who have business to discuss with the Committee shall have a hearing. Before noon of the following day, the Committee shall post a bulletin board near the entrance to the hall in which the Annual Meeting is being held, its nominations for each office to be filled, and shall formally present said nominations to the House at the time of the election. Additional nominations may be made from the floor by submitting the nominations without discussions or comment.

Section 3. The election of officers shall be held at the second meeting of the regular session of the House of Delegates.

Section 4. All elections shall be by secret ballot, and a majority of the votes cast shall be necessary to elect. Provided, however, that when there are more than two nominees, the nominee receiving the least number of votes on the first ballot shall be dropped and the balloting shall continue in like manner until an election occurs.

Section 5. Any member known to have directly or indirectly solicited votes for, or sought any office within the gift of the Association shall be ineligible for any office for two years.

Section 6. The Delegates representing the counties in each District shall form the Nominating Committee for the purpose of nominating a Trustee for the District concerned. This committee shall hold a well publicized meeting open to all active members of the District concerned who are in attendance at the Annual Meeting, for the purpose of discussing the nomination for the Trustee to serve the District. Additional nominations may be made from the floor when the Nominating Committee makes its report to the House of Delegates.

CHAPTER V. DUTIES OF OFFICERS

Section 1. Except as provided in Chapter II, Section 2 hereof, the President shall preside at all scientific sessions of the Association and shall appoint all committees not otherwise provided for. He shall deliver an annual address at such time as may be arranged and shall perform such duties as custom and parliamentary usage may require. He shall be the real head of the profession in the State during his term of office and so far as practicable, shall visit by appointment, the various sections of the State and assist the Trustees in building up the county societies and in making their work more practical and useful. He shall be reimbursed for his reasonable and necessary travel expense incurred in the performance of his duties as President, in an amount not to exceed the total amount appropriated for that purpose in the annual budget.

Section 2. The President-Elect shall assist the President in visitation of county and other meetings. He shall become president of the Association at the next Annual Meeting following his election as president-elect. In the event of his death or resignation, or if he becomes permanently disqualified or disabled, his successor shall be elected by the House of Delegates and shall be installed as President of the Association at its next regular session.

Section 3. The Vice Presidents shall assist the President in the discharge of his duties, and shall perform such other duties as may be prescribed by the Board of Trustees. In the event of a vacancy in the office of the President, the Vice President from the district from which the President was elected shall succeed to the office of the President.

Section 4. The President-Elect and the Vice Presidents, when acting for and in behalf of the President, may be reimbursed for their reasonable and necessary travel expenses incurred in the performance of their duties, in such amounts as may be available out of the sum appropriated in the annual budget for traveling expenses of the President.

Section 5. The Speaker of the House shall preside at all meetings of the House of Delegates. He shall appoint all committees of the House of Delegates with the approval of the House of Delegates. He shall be a

non-voting member of said committees, and shall perform such other duties as custom and parliamentary usage may require.

Section 6. The Vice Speaker shall assume the duties of the Speaker in his absence, and shall assist the Speaker in the performance of his duties. In the event of the death, disability, resignation, or removal of the Speaker, the Vice Speaker shall automatically become Speaker of the House of Delegates.

Section 7. The Secretary shall advise the Executive Secretary in all secretarial matters of this Association and shall act as the corporate secretary insofar as the execution of official documents or institution of official actions are required. He shall perform such duties as are placed upon him by the Constitution and Bylaws, and in the event of the death, resignation or removal of the Executive Secretary, shall assume the duties of that office until the vacancy is filled.

Section 8. The Treasurer shall demand and receive all funds due the Association, including bequests and donations. He shall, if so directed by the House of Delegates, sell or lease any real estate belonging to the Association and execute the necessary papers and shall, subject to such direction, have the care and management of the fiscal affairs of the Association. All vouchers of the Association shall be signed by the Secretary or the Executive Secretary and shall be countersigned by the Treasurer of the Association. Under unusual circumstances, when one or more of the above-named officials are not readily available, the President or the Chairman of the Board of Trustees is authorized to sign the vouchers, provided that in any event all vouchers of the Association shall bear a signature and a counter-signature. All five officials shall be required to give bond in an amount to be determined by the Board of Trustees. The Treasurer shall report the operations of his office annually to the House of Delegates, via the Board of Trustees, and shall truly and accurately account for all funds belonging to the Association and coming into his hands during the year. His accounts shall be audited annually by a certified public accountant appointed by the Board of Trustees.

CHAPTER VI. BOARD OF TRUSTEES

Section 1. The Board of Trustees shall be the executive body of the House of Delegates and between sessions of the House of Delegates shall exercise the powers conferred upon the House of Delegates by the Constitution and Bylaws. The Board of Trustees shall consist of the duly elected Trustees and the President, the President-Elect, the three Vice Presidents, the immediate Past-President, the Speaker, and Vice-Speaker of the House of Delegates, the Secretary, the Treasurer, and the Delegates to the American Medical Association. The Executive Committee of the Board of Trustees shall consist of the President, the President-Elect, the Secretary, the Chairman of the Board of Trustees, the Vice Chairman of the Board of Trustees, and two Trustees to be elected annually by the Board of Trustees. A majority of the full Board, to-wit, 14, and a majority of the full Executive Committee, to-wit, 4, shall constitute a quorum for the transaction of all business by either body. Between sessions of the Board, the Executive Committee shall exercise all of the powers belonging to the Board except those powers specifically reserved by the Board to itself.

Section 2. The Board shall meet daily, or as required, during the Annual Meeting of the Association and at such other times as necessity may require, subject to the call of the Chairman or on petition of three Trustees. It shall meet on the last day of the Annual Meeting for reorganization and for the outlining of the work for the ensuing year. It shall, through its Chairman, make an annual report to the House of Delegates at such time as may be provided, which report shall include an audit of the accounts of the Treasurer and other agents of this Association and which shall also specify the character and cost of all the publications of the Association during the year, and the amounts of all other property belonging to the Association, or under its control, with such suggestions as it may deem necessary. By accepting or rejecting this report, the House may approve or disapprove the action of the Board of Trustees in whole or in part, with respect to any matter reported upon therein. In the event of a vacancy in any office other than that of President, the Board may fill the same until the annual election.

Section 3. Each Trustee shall be organizer, peacemaker and censor for his district. He shall visit each county in his district at least once a year for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession and for improving and increasing the zeal of the existing component societies and their members. He shall likewise hold at least one district meeting each year in order to afford a forum for the exchange of views on problems relating to organized medicine and for postgraduate scientific study. The necessary traveling expenses incurred by a Trustee in the line of his duties herein imposed may be paid by the Treasurer upon a proper itemized statement, but this shall not be construed to include his expenses in attending the Annual Meeting of the Association.

Section 4. Collectively the Board shall be the Board of Censors of the Association. It shall consider all questions involving the right and standing of members, whether in relation to other members, to the component societies, or to this Association. All questions of an ethical nature brought before the House of Delegates shall be referred to the Board without discussion. It shall hear and decide all questions of discipline affecting the conduct of members or a component society upon which appeal is taken from the decision of an individual Trustee or District Grievance Committee. In hearing appeals, the Board may admit such oral or written evidence as in its judgment will best and most fairly present the facts, but in case of every appeal, efforts toward conciliation and compromise shall precede all such hearings. Its decision in all such cases shall be final.

Section 5. The Board shall have the right to communicate the views of the profession and of the Association in regard to health, sanitation, and other important matters, to the public and press. Such communications shall be signed by the President of the Association and the Chairman of the Board.

Section 6. The Journal of the Kentucky State Medical Association shall be the official organ of the Association and shall be published under the supervision of the Board. The Editor of the Journal shall be elected by the Board. All money received by the Journal or by any member of its staff on its behalf, shall be paid to the Treasurer on the first of each month. The Board shall provide for and superintend the publication and distribution of all proceedings, transactions, and memoirs of the Association, and shall have authority to appoint such assistants to the Editor as it deems necessary.

Section 7. All commercial exhibits during the Annual Meeting shall be within the control and direction of the Board.

Section 8. In the event of the death, resignation, removal or disability of a Trustee, between sessions of the House of Delegates, the President may call a meeting of the delegates of record from the counties of that district for the purpose of submitting one or more nominees as candidates to fill the office until the Trustee's disability is removed or until the next meeting of the House of Delegates. The name or names of the nominee or nominees shall be submitted to the Board, which may elect an acting Trustee from them.

Section 9. A Medico-Legal Administrator shall be appointed by the Board to serve for a term of three years. The Executive Committee of the Board shall act in an advisory capacity to the Administrator. The Association, through the Administrator shall, upon the request of any member in good standing who is

a defendant in a professional liability suit, provide such member with the consultative service of competent legal counsel selected by the Administrator acting under the general direction of the Executive Committee. In addition, the Association may, upon application to the Board outlining unusual circumstances justifying such action, provide such member with the services of an attorney selected by the Board to defend such suit through one court.

Section 10. The Board shall employ an Executive Secretary whose principal duty shall be to carry out and execute the policies established by the House of Delegates and the Board. His compensation shall be fixed by the Board. The Executive Secretary shall act as general administrative officer and business manager of the Association and shall perform all administrative duties necessary and proper to the general management of the Headquarters Office, except those duties which are specifically imposed by the Constitution and Bylaws upon the officers, committees, councils and other representatives of the Association. He shall refer to the various elected officials all administrative questions which are properly within their jurisdiction.

He shall attend the Annual Meeting, the meetings of the House of Delegates, the meetings of the Board, as many of the committee and council meetings as possible, and shall keep separately the records of their respective proceedings. He shall, at all times, hold himself in readiness to advise and aid, so far as is possible and practicable, all officers, committees, and councils of the Association in the performance of their duties and in the furtherance of the purposes of the Association. He shall be allowed traveling expenses to the extent approved by the Board.

He shall be the custodian of the general papers and records of the Association (including those of the Treasurer) and shall conduct the official correspondence of the Association. He shall notify all members of meetings, officers of their election, and committees and councils of their appointment and duties.

He shall account for and promptly turn over to the Treasurer all funds of the Association which come into his hands. It shall be his duty to receive all bills against the Association, to investigate their fairness and correctness, to prepare vouchers covering the same, and to forward them to the Treasurer for appropriate action. He shall keep an account with the component societies of the amounts of their assessments, collect the same, and promptly turn over the proceeds to the Treasurer. He shall within thirty days preceding each Annual Meeting, submit his financial books and records to a certified public accountant, approved by the Board, whose report shall be submitted to the House of Delegates.

He shall keep a card index register of all practitioners in the State by counties, noting on each his status in relation to his county society and upon request shall transmit a copy of this list to the American Medical Association.

He shall act as Managing Editor of the Journal of the Kentucky State Medical Association under supervision of the Board and in a similar capacity to the extent that other publications are authorized by the House of Delegates.

He shall perform such additional duties as may be required by the House of Delegates, the Board, or the President, and shall employ such assistants as the Board may direct. He shall serve at the pleasure of the Board, and in the event of his death, resignation, or removal, the Board shall have the power to fill the vacancy. From time to time, or as directed by the Board, he shall make written reports to the Board and House of Delegates concerning his activities and those of the Headquarters Office.

CHAPTER VII. STANDING COMMITTEES AND COUNCILS

Section 1. The Board of Trustees shall, upon nomination of its Executive Committee, appoint and designate the chairmen of five standing committees composed of not less than five nor more than seven members, as follows:

(a) A Committee to Study the Constitution and Bylaws
(b) A Committee on Third-Party Medicine
(c) A Committee on Professional Relations
(d) A Committee on Arrangements for the Interim Meeting.
(e) An Advisory Committee to the Editor of the Journal

Section 2. The Board of Trustees shall, in the same manner, (except as hereinafter provided) appoint and designate the chairmen of six Councils, composed of not less than five nor more than seven members, as follows:

(a) A Council on Scientific Assembly.
(b) A Council on Medical Education and Hospitals.
(c) A Council on Legislative Activities.
(d) A Council on Medical Services.
(e) A Council on Communications and Public Service.
(f) A Council on Allied Professions and Related Groups.

Section 3. The Executive Committee shall serve as the nominating committee for all Standing Committee and Council appointments, but the Trustees may make additional nominations from the floor. When the Executive Committee sits as such nominating committee, the President shall serve as Chairman.

Section 4. Except as otherwise provided herein, members of Standing Committees and Councils shall be appointed for terms of not less than one year and of not more than three years, and until their successors are appointed. Each committee and council (other than the Council on Scientific Assembly) shall meet and organize as soon after its appointment as possible, and shall meet again near the close of the associational year, for the purpose of formulating its annual report. It may meet at such other times as may be necessary or desirable. The Headquarters Office shall be the headquarters for all Committees and Councils, unless otherwise specifically ordered by the Board of Trustees or its Executive Committee.

Five-member Committees and Councils shall have a quorum of three, and seven-member Committees and Councils shall have a quorum of four members present before any business other than the fixing of the time and place of the next meeting, may be transacted.

Each Standing Committee and Council shall report annually, at least six weeks prior to the Annual Meeting, to the House of Delegates via the Board of Trustees respecting its activities during the year last past. These reports shall be transmitted, without alteration or amendment, to the House of Delegates by the Board of Trustees at the Annual Meeting, with such comments or recommendations as the Board cares to make. Committees and Councils may submit supplemental reports if such reports are in the hands of the Secretary at least 48 hours in advance of the first meeting of the Regular Session of the House of Delegates.

Section 5. The President, Secretary, and Executive Secretary shall be ex officio members of all Committees and Councils, without power to vote except as otherwise specified herein.

Section 6. The Board of Trustees shall have power to establish such other committees as may, from time to time, appear to it to be advisable, and to prescribe their composition, the method of their appointment, and their duties. Such committees shall serve at the pleasure of the Board.

In addition, the Board of Trustees shall have power to appoint a representative from this Association to the Conference of Presidents and such other organizations as it shall determine.

Section 7. The Committee to Study the Constitution and Bylaws shall make a continuing study of the Constitution and Bylaws and shall annually recommend such revisions of either or both of these documents as changing times and conditions indicate.

Section 8. The Committee on Third Party Medicine shall make a continuing study of Third Party Medicine, and shall maintain liaison with all medical care plans which employ physicians on a salaried basis in this state. It shall mediate disputes between members and such plans, and shall continually strive to persuade such plans to shape their relations with their employed physicians and with the public, in conformity to the views of this Association.

Section 9. The Professional Relations Committee shall supervise and coordinate the work of the various District Grievance Committees hereinafter created. The Trustee of each District is hereby designated the Chairman of his District Grievance Committee. The Professional Relations Committee shall designate two (2) additional Trustees from Districts adjoining that of the Chairman, and the three Trustees thus selected shall constitute the District Grievance Committee. All grievances which cannot be resolved by individual Trustees, shall be referred to the District Grievance Committee for the District in which the respondent physician or county society resides. If requested to do so, the District Grievance Committee shall hold hearings and hear evidence and render a decision based upon the evidence thus presented. Any party aggrieved by the decision of the District Grievance Committee, shall have the right to appeal to the Board of Trustees in the manner provided by Section 4 of Chapter VI of these Bylaws.

All grievances, whether handled by individual Trustees or by District Grievance Committees, shall be reported to the Professional Relations Committee, which shall include in its report to the Board of Trustees, a statistical resume of the number of cases handled and the disposition thereof. In addition, the Professional Relations Committee shall make recommendations to the Board of Trustees with respect to any course of action which the Committee determines to be desirable, in the light of its experience during the year covered by its report.

Section 10. The Committee on Arrangements for the Interim Meeting shall have the responsibility of preparing the program for the Interim Meeting, and presenting it to the Board of Trustees or its Executive Committee for approval. Upon approval of the program thus presented, the Committee shall have the further responsibility of approving all arrangements for the Conference.

Section 11. The Advisory Committee to the Editor of the Journal shall provide support to the Editor and be available to him for consultation with respect to any matter concerning the Journal, on which he desires the Committee's advice and assistance. All papers of doubtful suitability for publication shall be referred by the Editor to the Advisory Committee, and its approval shall be required prior to the publication of any matter which is recognized to be of a controversial nature.

Section 12. The Council on Scientific Assembly shall consist of seven (7) members. The President, the President-Elect, and the chairmen of the Committees on Scientific and Technical Exhibits shall, by virtue of their respective offices, be voting members of the Council, with the President serving as Chairman and the President-Elect as Vice-Chairman. The remaining three members shall serve for terms of three (3) years each, with the term of one member expiring each year. The Council shall supervise and direct the planning, development and presentation of the scientific programs of the Annual Meeting each year. In addition, it shall be responsible for scientific and technical exhibits and all activities incident to the Annual Meeting, including golf and other forms of recreation and entertainment. These will include the duties heretofore imposed upon the Awards Committee to nominate the recipients of the Distinguished Service Medal, the Outstanding General Practitioner Award, and the R. Haynes Barr Award.

Thirty (30) days previous to each Annual Meeting, the Council shall prepare and issue a program announcing the order in which papers, discussions, and other business shall be presented, which program shall be adhered to as nearly as practicable. No county society, as such, shall serve as host society to the Annual Meeting.

Section 13. The Council on Medical Education and Hospitals shall direct and supervise the activities of the Association in the field of medical education, and shall maintain active liaison with the Kentucky Hospital Association. It shall seek to elevate the standards of postgraduate medical education in Kentucky, establishing and maintaining liaison with Kentucky's two medical schools and the Committee for the American Medical Education Foundation, and concerning itself with problems relating to medical and hospital care, general practice, and such other matters in this general field as may be referred to it by the Board.

Section 14. The Council on Legislative Activities shall direct and supervise the work of the Association as it pertains to state and national legislation, and shall formulate and submit a legislative program to the Board of Trustees for its consideration. The Council shall seek the enactment of the Association's legislative program into law, and shall resist the enactment of bills which the Board finds to be not in the best interests of the public or the profession. It shall maintain liaison with officials of state and national governments and shall work closely with the various county societies in carrying out the legislative program at both state and national levels.

Section 15. The Council on Medical Services shall supervise and direct the activities of the Association in the field of socio-economic development. It shall be charged with the promotion of voluntary health insurance programs in general and shall maintain active liaison with Kentucky Physicians Mutual, Inc., and Blue Cross plans. It shall advise on medical service contracts with the state and federal governments and shall serve as a clearing house on all fee schedules and other questions affecting the economics of medicine. It shall concern itself with the problem of providing adequate medical care for the aged, and shall maintain careful scrutiny of all state or national programs which purport to deal with this problem.

Section 16. The Council on Communications and Public Service shall supervise and direct all associational activity in the fields of public relations and service, including, but not limited to, rural health, schools, public health, emergency medical services and diabetes.

Section 17. The Council on Allied Professions and Related Groups shall concern itself with the development and promotion of improved health standards and shall establish and maintain liaison with the dental, nursing and pharmacy professions in this state. It shall supervise and direct the Association's activities in the fields of infant and maternal mortality, physical medicine and rehabilitation, industrial medicine, tuberculosis, blood banks and other related subjects, and shall interest itself in the work of voluntary health associations.

CHAPTER VIII. ASSESSMENTS AND EXPENDITURES

Section 1. The annual dues for membership in this Association shall be as follows: (1) Active Members, $50, except Active Members who devote all of their time to teaching or research and have no private practice, $25; (2) Emeritus Members, no dues; (3) Associate Members, $8; (4) Inactive Members, $8; (5) Student Members, $1; (6) Honorary Members, no dues; (7) Special Members, no dues. Dues fixed by these Bylaws shall constitute assessments against the component societies. The Secretary of each component society shall forward its assessment together with its roster of all officers and members, list of delegates, and list of non-affiliated physicians of the county to the Secretary of this Association as of the first day of January in each year.

Section 2. Any component society which fails to

pay its assessments, or make the report as required, on or before the first day of April in each year, shall be held as suspended and none of its members or delegates shall be permitted to participate in any of the business or proceedings of the Association or of the House of Delegates until such requirements have been met.

Section 3. All motions and resolutions appropriating money shall specify a definite amount or so much thereof as may be necessary for the purpose, and must have prior approval of the Board of Trustees before they can become effective.

CHAPTER IX. RULES OF CONDUCT

The principles set forth in the Principles of Ethics of the American Medical Association, together with the Constitution and Bylaws of the Association and all duly adopted resolutions of the House of Delegates, shall govern the conduct of members in their relation to each other and to the public.

CHAPTER X. RULES OF ORDER

The deliberations of this Association shall be governed by parliamentary usage as contained in Robert's Rules of Order, unless otherwise determined by a vote of its respective bodies.

CHAPTER XI. COUNTY SOCIETIES

Section 1. Except as provided in Section 4 of this Chapter, all county medical societies in this state which have adopted principles of organization not in conflict with this Constitution and Bylaws shall, upon application to the House of Delegates, receive a charter from and become a component part of this Association.

Section 2. As rapidly as can be done after the adoption of this Constitution and Bylaws, a medical society shall be organized in every county in the state in which no component society exists, and charters shall be issued thereto.

Section 3. Charters shall be issued only upon approval of the House of Delegates and shall be signed by the President and Secretary. The House of Delegates shall have authority to revoke the charter of any component society whose actions are in conflict with the letter or spirit of this Constitution and Bylaws.

Section 4. Only one component society shall be chartered in any county except that the House of Delegates may issue a charter to one statewide society of worthy Negro physicians who are not members of any component society. Membership in the component society thus created shall entitle the members thereof to all the rights and benefits of membership in the Kentucky State Medical Association.

Section 5. In sparsely settled sections two or more component societies may join for scientific programs, the election of officers, and such other matters as they may deem advisable. The component societies thus combined shall not lose any of their privileges or representation. The active members of each component society shall annually elect at least a Secretary and a Delegate for the transaction of its business with the Association.

Section 6. Each component society shall be the sole judge of the qualifications of its own members. All members of component societies shall be members of the Kentucky State Medical Association, and shall be classified in accordance with Chapter I, Section 2, of these Bylaws. Any physician who desires to become a member of the Kentucky Medical Association shall first apply to the component society in the county in which he resides, for membership therein. Except as hereinafter provided in Sections 7 and/or 9 of this chapter, no physician shall be an active member of a component society in any county other than the county in which he resides.

Section 7. Any physician who may feel aggrieved by the action of the component society of the county in which he resides, in refusing him membership, shall have the right to appeal to the Board of Trustees, which, upon a majority vote, may permit him to apply for membership in a component society in a county which is adjacent to the county in which he resides. (Disciplinary procedures are governed by Section 4, Chapter VI of these Bylaws.)

Section 8. When a member in good standing in a component society moves to another county in the State, his name, upon request, shall be transferred without cost to the roster of the component society into whose jurisdiction he moves, if he is admitted to membership therein.

Section 9. A physician whose residence is closer to the headquarters of an adjacent component society than it is to the headquarters of the component society of the county in which he resides, may, with the consent of the component society within whose jurisdiction he resides, hold membership in said adjacent component society.

Section 10. Each component society shall have general direction of the affairs of the profession in the county, and its influence shall be constantly exerted for bettering the scientific, moral and material conditions of every physician in the county. Systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it embraces every qualified physician in the county.

Section 11. Frequent meetings shall be encouraged, and the most attractive programs arranged that are possible. The younger members shall be especially encouraged to do postgraduate and original research work, and to give the society the first benefit of such labors. Official positions and other references shall be unstintingly given to such members.

Section 12. At the time of the annual election of officers, each component society shall elect a delegate or delegates to represent it in the House of Delegates. The term of a delegate shall commence on the first day of the regular session of the House following his election, and shall end on the day before the first day of the next regular session. Provided, however, that component societies may elect delegates for more than one term at any election. Each component society may elect one delegate for each 25 members in good standing, plus one delegate for one or more members in excess of multiples of 25. Provided, however that each component society shall be entitled to at least one delegate regardless of the number of members it may have and the secretary of the society shall send a list of such delegates to the Secretary of this Association not later than 45 days before the next Annual Meeting. It shall be the obligation of a component society which elects delegates to serve more than one year, to provide the KSMA Headquarters Office with a certified list of its delegates each year.

Section 13. The secretary of each component society shall keep a roster of its members and a list of non-affiliated licensed physicians of the county, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this State, and such other information as may be deemed necessary. He shall furnish an official report containing such information upon blanks supplied him for the purpose, to the Secretary of the Association, on the first day of January of each year, or as soon thereafter as possible, and at the same time the dues accruing from the annual assessment are sent in. In keeping such roster the secretary shall note any change in the personnel of the profession by death or by removal to or from the county, and in making his annual report he shall be certain to account for every physician who has lived in the county during the year.

Section 14. The secretary of each component society shall report to the Journal of the Kentucky State Medical Association full minutes of each meeting and forward to it all scientific papers and discussions which the society shall consider worthy of publication.

CHAPTER XII. AMENDMENTS

These Bylaws may be amended at any session of the House of Delegates by a two-thirds vote of all the delegates present at that session, after the amendment has laid on the table for one day.



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1. Barden, F. W., et al.: J. Maine M. A. 46:99, 1955.
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